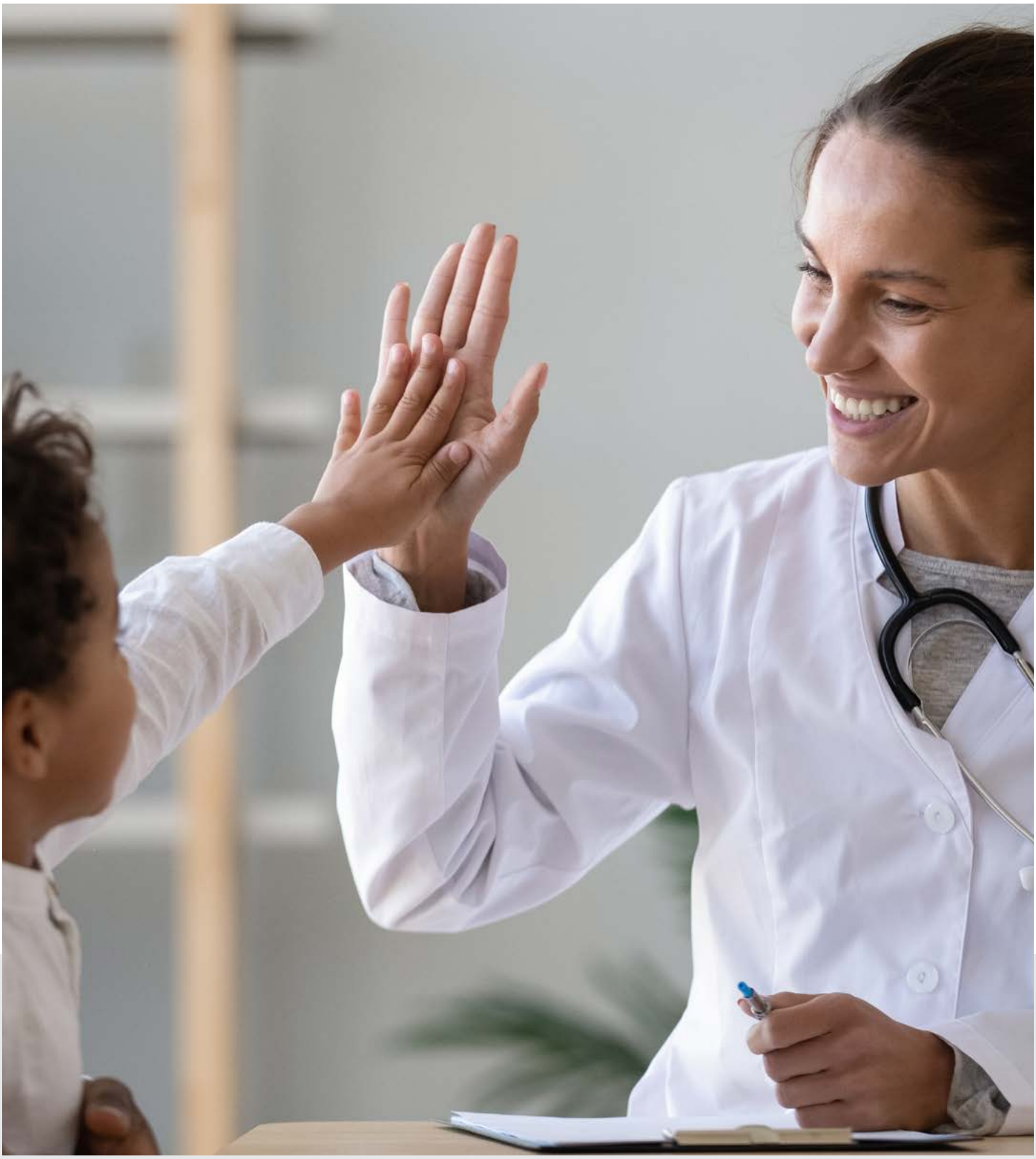
UPHP
UPPER PENINSULA HEALTH PLAN

2024

PROVIDER MANUAL



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Introduction

About UPHP

Based in Marquette, MI, Upper Peninsula Health Plan (UPHP) is a managed care organization providing health coverage to individuals enrolled in UPHP programs. UPHP programs include the following: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, and MI Health Link. MI Health Link is a Medicare-Medicaid Plan for those that are dual eligible. UPHP's network has over 3,900 providers, and our service area includes all 15 counties of the Upper Peninsula, as well as locations in Lower Michigan, Wisconsin, and Minnesota. Our combined enrollment exceeds 50,000 members, and we employ more than 150 individuals.

Mission

Advancing the health and well-being of the communities we serve.

Vision

A healthy Upper Peninsula with people living their best lives.

Values

While UPHP's impact on health care in the Upper Peninsula has grown since we began operating in 1998, our inherent values have not changed. These are the values that guide us in our work:

- **Members First:** We believe we are accountable to the residents of the Upper Peninsula. We aspire to be our members' trusted advisor and partner providing access to the highest quality care.

- **Partnership with Providers:** We believe the Upper Peninsula's hospitals and healthcare providers are valuable partners to improve our members' quality of life and promote wellness. The best healthcare solutions come from collaboration with our network of providers.

- **Valued Employees and Volunteers:** Our culture is distinct and essential to our success, and it begins with our team. We seek out bright, engaging people and support their growth to nurture dynamic careers and offer impactful volunteer opportunities.

- **Connected to Communities:** We believe access to resources and information leads to better health. We strive to build healthier communities and empower people to make smarter decisions about their health.

Disclaimer

Providers must comply with all terms of the plan and provider contract, as well as all federal and state regulations governing the plan and the provider. UPHP may or may not communicate such terms in forms other than the contract and this provider manual. Providers are required to understand and apply Michigan Medicaid Health Care Program and Centers for Medicare and Medicaid Services (CMS) requirements.

For additional information, please refer to the following documents:

- **For Medicare** — Centers for Medicare and Medicaid (CMS) Online Manual System: www.cms.gov/manuals

- **For Medicaid** — Michigan Department of Health and Human Services (MDHHS) Provider Manual: www.mdch.state.mi.us/dch-medicaid/manuals/medicaidprovidermanual.pdf

Contact Information

Department	Telephone Number Medicare (TTY 711)	Telephone Number Medicaid (TTY 711)	Fax Number
Behavioral Health Services - North Care	888-333-8030	888-333-8030	906-225-7352
Customer Service	877-349-9324	800-835-2556	906-225-7690
Fraud and Abuse Prevention	877-349-9324	800-835-2556	906-225-8688
Magellan RX Prior Authorization Help Desk	855-380-0275	248-540-6686	Not Applicable
Medical Pharmacy J-Code Prior Authorizations	Not Applicable	906-232-1628	906-225-4516
Medical Claims Address: 853 West Washington St. Marquette, MI 49855	877-349-9324	800-835-2556	906-225-8770
Medical Claims Services and Provider Appeals	877-349-9324	800-835-2556 **OR** 906-225-7746	906-225-7720
Medical Services Prior Authorization and Utilization Management	877-349-9324	800-835-2556 **OR** 906-225-7774	906-225-9269
Provider Portal/Help Desk	906-225-6811	906-225-6811	906-225-9255
Provider Relations/Contracting	877-349-9324	800-835-2556	906-225-1087
Transportation	800-835-2556	800-835-2556	906-225-7690

Accessing Language Line Services

Upper Peninsula Health Plan (UPHP) can arrange for an interpreter to speak to a member in any language, free of charge. A member may call UPHP Customer Service to access interpretive services. A member may identify providers who speak their preferred language by calling Customer Service or by using the UPHP Provider Search tool, available online at www.uphp.com.

The Michigan Relay Center makes it possible for hearing-impaired and/or speech-impaired persons to call UPHP 24 hours a day, seven days a week. To connect through Michigan Relay, dial 7-1-1.

Member Rights and Responsibilities

Members of Upper Peninsula Health Plan (UPHP) have rights and responsibilities regarding their health care and related services. UPHP providers must be aware of these rights and responsibilities. Newly credentialed providers receive this information in their Provider Orientation Packet. Please review these rights and responsibilities via the following links:

- **Medicaid & Healthy Michigan Plan:** Section 6 "Your Rights and Responsibilities"
  - https://www.uphp.com/medicaid/importantdocumentsforms/

- **MI Health Link:** Chapter 8 "Your Rights and Responsibilities"
  - https://www.uphp.com/medicare/uphp-mi-health-link/member-handbook/

Providers may also request a hardcopy of the Member Rights and Responsibilities by contacting uphpproviderrelations@uphp.com.

Eligibility and Enrollment Information

Eligibility

A member's eligibility may change monthly. Therefore, providers should verify a member's eligibility at the time of service. Services provided when a member is not enrolled with UPHP will not be covered by UPHP.

The following resources should be used to check the eligibility status of UPHP Medicaid, Healthy Michigan Plan (HMP), and MI Health Link (MHL) members:

- Community Health Automated Medicaid Processing System (CHAMPS): 800-292-2550
  - CHAMPS Web portal https://milogintp.michigan.gov

- UPHP Customer Service: 800-835-2556

- UPHP Assist Provider Portal: https://assist.uphp.com

Additional eligibility verification options are identified in the Michigan Medicaid Provider Manual/Directory Appendix/ Eligibility Verification. The manual can be found on the Michigan Department of Health and Human Services (MDHHS) website at https://www.michigan.gov/mdhhs/doing-business/providers/providers/medicaid/policyforms/medicaid-provider-manual.

Please note: The UPHP VisibilEDI Provider Claims Portal should not be used to verify eligibility.

UPHP MI Health Link (MHL)

The UPHP MHL Program is a complete integrated health care program available to individuals who meet all of the following criteria:

- Age 21 or older at the time of enrollment.
- Eligible for full benefits under Medicare Part A, enrolled under Medicare Parts B and D, and receiving full Medicaid benefits. (This includes individuals who are eligible for Medicaid through expanded financial eligibility limits under a 1915(c) waiver or who reside in a nursing facility and have a monthly patient pay amount.)
- Resides in UPHP's service area.

The following populations will be excluded from enrollment in the MHL Program:

- Individuals under the age of 21.
- Individuals previously disenrolled due to special disenrollment from Medicaid managed care as defined in 42 C.F.R § 438.56.
- Individuals not living in a demonstration region.
- Individuals with Additional Low Income Medicare Beneficiary/Qualified Individuals (ALMB/QI).
- Individuals without full Medicaid coverage (spend downs or deductibles).
- Individuals with Medicaid who reside in a state psychiatric hospital.
- Individuals with commercial HMO coverage.
- Individuals with elected hospice services.
- Individuals 21 years of age or older being served by the Children's Special Health Care Services program.
- Individuals who are incarcerated.
- Individuals who have presumptive eligibility.
- Individuals not eligible for Medicaid due to divestment.
- Individuals residing in designated State sanctioned Veterans' Homes.

CMS and MDHHS have sole responsibility for determining the eligibility of individuals for the MHL program. UPHP ensures mechanisms are in place to process enrollment and disenrollment data from CMS and MDHHS, or their authorized agent. UPHP shall accept for enrollment all potential enrollees identified by MDHHS at any time without regard to income status, physical or mental condition, age, gender, sexual orientation, religion, creed, race, color, physical or mental disability, national origin, ancestry, preexisting conditions, expected health status, or need for health care services. UPHP will not interfere with the enrollee's right to disenroll through threat, intimidation, pressure, or otherwise.

UPHP Medicaid, Healthy Michigan Plan & MIChild

Medicaid is a federal program created by Title XIX of the Social Security Act in 1965, which provides necessary medical and health services to those who would not otherwise have the financial resources to obtain them. Eligibility for services is determined by the Michigan Department of Health and Human Services (MDHHS) and applications should be filled out at the local MDHHS office.

Most people who receive Medicaid must join a health plan. Health plans provide Medicaid-covered health care services for an enrolled group of beneficiaries in a defined service area. After a Medicaid case is opened, Michigan ENROLLS (Michigan's enrollment broker) will contact the member about their health plan choices. For general questions and further information regarding Medicaid, call Michigan ENROLLS at 888-367-6557.

UPHP is notified each month when Medicaid beneficiaries are assigned to the plan. Members will have two cards. UPHP will send new members a UPHP identification (ID) card and the State of Michigan will send a Michigan Medicaid ID card (referred to as a mihealth card). The mihealth card contains information on the member's Medicaid eligibility, and although the member is enrolled in UPHP, they should present both cards each time they seek health care or services.

Newborns will automatically be enrolled with the mother's health plan at the time of birth. Newborn enrollment into the health plan may not be immediately reflected in the CHAMPS system.

Members who are disenrolled from UPHP due to loss of Medicaid eligibility will be automatically re- enrolled prospectively to UPHP if they regain eligibility within two months.

Occasionally, a Medicaid beneficiary may be retroactively determined eligible. Once a beneficiary (other than a newborn) is determined to be Medicaid eligible, enrollment with UPHP will occur on the first day of the next available month following the eligibility determination and enrollment process. UPHP will not be responsible for paying health care services during a period of retroactive eligibility and prior to the date of enrollment in the health plan, except for newborns.

Children's Special Health Care Services (CSHCS) is a program within the Michigan Department of Health and Human Services (MDHHS). This program is for children and some adults with health care needs and their families. CSHCS members do not have any copayments.

Direct any questions about a beneficiary who is re-enrolled or gains retroactive eligibility to UPHP Customer Service.

Special Disenrollment (UPHP Medicaid, Healthy Michigan Plan, and MI Health Link Programs)

UPHP may initiate and submit special disenrollment requests to MDHHS if a member acts in a violent or threatening manner. Violent/life-threatening situations involve physical acts of violence (physical or verbal threats of violence made against providers, staff, or the public) or stalking situations.

A member may not be disenrolled based on physical or mental health status. If a member's physical or mental health is a factor in the actions conflicting with UPHP membership, UPHP must assist the member in correcting the problem, which includes making the appropriate physical and mental health referrals.

UPHP must contact law enforcement, when appropriate, before seeking disenrollment of members who exhibit violent or threatening behavior. MDHHS may require additional information from UPHP to evaluate the appropriateness of the disenrollment. The effective disenrollment date should be within 60 days from the date MDHHS received the complete request. If the member appeals this decision, the effective disenrollment date should be no later than 30 days following the resolution of the appeal.

To initiate a special disenrollment request, please contact UPHP Customer Service. The provider should provide UPHP with the following documentation, if applicable, for special disenrollment:

- An incident report or summary of member actions.
- A copy of the provider dismissal letter or correspondence to the member.
- A copy of a police report, including a reference number given by the police department.

Benefits Monitoring Program (UPHP Medicaid and Healthy Michigan Plans only)

State and federal regulations require MDHHS and UPHP to conduct surveillance and benefits utilization review to ensure the appropriate amount, scope, and duration of medically necessary services are being provided to UPHP members. The Benefits Monitoring Program (BMP) is in place to closely monitor program usage and to identify members who may be potentially overutilizing or misusing their UPHP Medicaid services and benefits.

Members are enrolled in BMP when UPHP determines any of the following criteria (alone or in combination) apply to an individual:

- The member is suspected or has been convicted of fraud, such as altering prescriptions to obtain medical services, products, or pharmaceuticals.
- The member is misusing emergency department services, such as going to the emergency room for non-emergent conditions.
- The member is misusing pharmacy services, such as utilizing more than three different pharmacies in one quarter.
- The member is misusing physician services, such as obtaining duplicate or similar services from more than one physician or physician extender in different practices. UPHP will also review additional criteria as misutilization patterns emerge or are identified by the plan.

UPHP members enrolled in the BMP are in the program for at least 24 months and will be restricted to approved providers and a pharmacy. Qualifications of assigned BMP providers include: agrees to treat BMP member, assists BMP member with utilization, and follows UPHP BMP procedures (i.e. referrals to other providers).

If UPHP has reason to suspect that a selected provider will not contribute to a reduction in utilization, the selection may be denied. UPHP reserves the right to end/terminate provider authorization for a BMP member at any time. A replacement provider will be assigned following such an action. Instances will be determined on a case-by-case basis following periodic review and must meet at least one of the following criteria:

- A review of utilization reveals that the provider is not contributing to a reduction in service utilization (including the use of drugs subject to abuse) as defined by the BMP.
- The BMP authorized provider becomes a sanctioned provider, or
- The BMP authorized provider makes referrals to the emergency department for non-emergent conditions.

The following services are exempt from the BMP control mechanisms:

- Emergency services.
- Dental services.
- Durable medical equipment (DME) services.
- Services rendered by a nursing facility provider.
- Services rendered in an inpatient hospital.
- Hospice services.
- Vision services.
- Services rendered at local health departments (LHDs).
- Hearing services.
- Podiatry services.
- Chiropractic services.
- Services rendered by a non-prescribing mental health provider (i.e. MSW, PhD, professional counselor, etc.).
- Sexually transmitted infection (STI) screening/treatment, family planning, and related services.

All providers MUST verify eligibility before providing service(s). BMP members are indicated on the CHAMPS Eligibility Inquiry Response as additional information. If the BMP Provider Restriction Indicator is "Y," the hyperlink will be activated. The hyperlink will open the BMP restrictions page, which contains the BMP-authorized provider information. If there is no provider listed, the member is restricted only by the pharmaceutical refill tolerance for that date of service.

It is the responsibility of the BMP primary care provider (PCP) to coordinate all prescribed drugs, specialty care, and ancillary services for BMP members. Reimbursement for any ambulatory service will not be made unless the service was provided, referred, prescribed, or ordered by the PCP and/or, if applicable, an approved UPHP authorization number is in place.

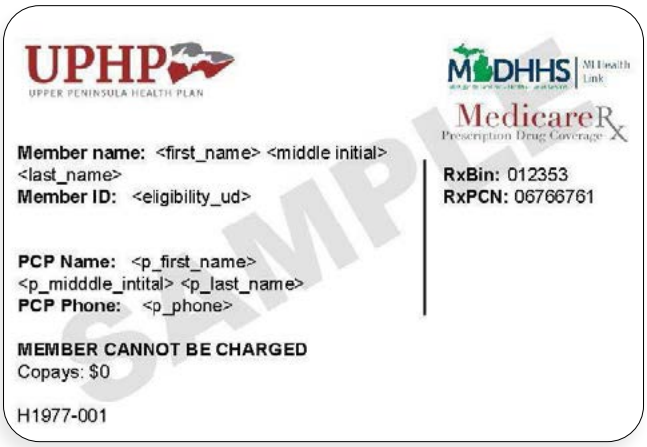
The BMP PCP must complete the UPHP Prior Authorization & Notification Form to notify UPHP of the need to authorize care by other providers, medical clinics, and outpatient hospitals. This form must be completed and submitted to UPHP prior to services being rendered. UPHP will determine whether to issue an authorization to be billed on all claims provided by the referred provider(s) for the BMP member. This request by the BMP PCP does not replace any prior authorization (PA) required by UPHP (i.e. out-of- network services, cosmetic surgery). All PA requests must follow UPHP Policy #300-005: Utilization Management Process.

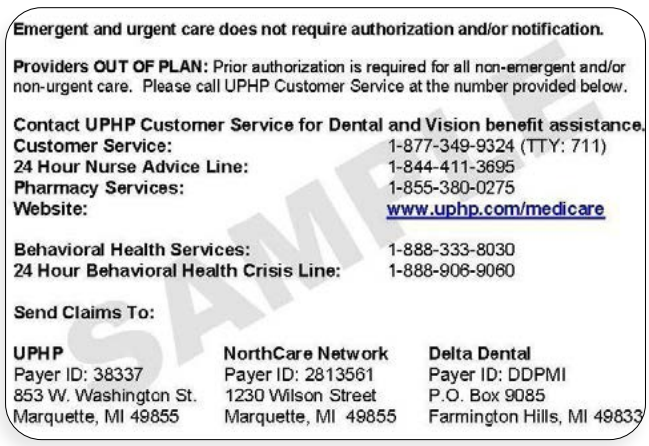
Only a provider listed on the member's BMP authorized provider list or having an approved UPHP authorization number will be reimbursed by UPHP. If a provider already has an approved authorization number in place and wishes to order any restricted services and/or restricted medications, or feels referral to another physician is needed, these activities must be coordinated with the member's PCP. The referring provider or the PCP must either contact the clinical coordinator or submit the UPHP Prior Authorization & Notification Form for the additional requested services prior to the services being rendered. This will allow UPHP to issue an authorization number for the services or identify the referring provider as an authorized prescriber of a restricted medication.

If you think one of your patients is a candidate for the BMP program, call UPHP Customer Service or fill out the Care Coordination/Case Management Referral Form located on the UPHP website at https://www.uphp.com/providers/forms- links/.

Member Identification Cards

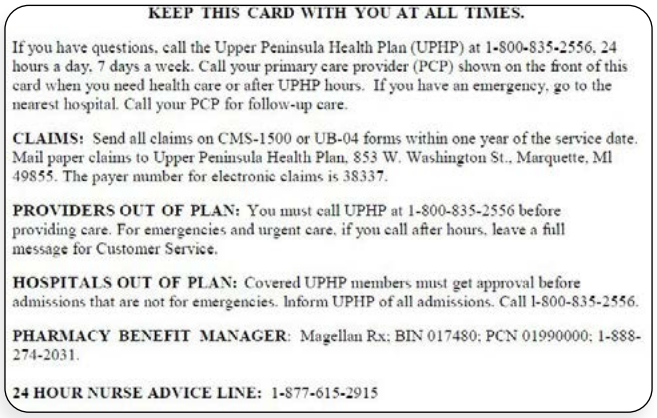
MIHealth Link





Medicaid, Healthy Michigan Plan and MI Child

UPHP-issued ID Card



Mihealth ID Card *(state-issued)*

Changing a Primary Care Provider (PCP) Member

MI Health Link

UPHP MHL, members can change their PCP at any time. Members wanting to change their PCP must call UPHP Customer Service.

Medicaid, Healthy Michigan Plan and MIChild

UPHP Medicaid, HMP, and MIChild members are allowed to change their PCP every 90 days without cause. Exceptions to this 90-day rule include:

- New members are allowed to change their PCP in the first 30 thirty days upon enrollment; thereafter, they are held to the one PCP change every 90 days.
- Member moves and is more than 40 miles from their current assigned PCP.
- Practitioner terminates and member must choose a new PCP..
- Quality of care issues that are substantiated by the UPHP Medical Director.
- Member has a grievance with the PCP or office that cannot be resolved to the satisfaction of the PCP or the member.
- PCP releases the member from their practice for any reason (i.e. non-compliant behavior).
- CSHCS members may change their PCP at any time.

A member may request a PCP change by calling or sending written notification to UPHP Customer Service. Members may also request a PCP change when speaking with their care coordinator; this request will be routed to UPHP Customer Service for processing. UPHP recommends members choose a PCP within 40 minutes or 40 miles of travel, or as close to home as possible. County boundaries are not used to limit PCP choice or assignment.

Provider

If a PCP requests a member to be transferred to a different PCP, the current PCP should inform the member in writing of the reason(s) for terminating the current physician-patient relationship and inform the member they have 30 days to choose another PCP.

The PCP should send a copy of the correspondence to UPHP at:

UPHP Customer Service
853 West Washington Street Marquette, MI 49855
Fax: 906-225-7690

Cost Sharing

MI Health Link

There is no cost sharing for MHL covered services. Patient Pay Amounts (PPA) are collected by the nursing facility from members for traditional Medicaid days of nursing home care on a monthly basis.

Medicaid

There are no copayments or deductibles for UPHP-covered services for UPHP Medicaid.

Healthy Michigan Plan (HMP)

There is no cost sharing for UPHP-covered services for UPHP HMP.

Program Benefits and Services

Upper Peninsula Health Plan (UPHP) has a comprehensive benefits package available to members. Services are limited to those that are medically necessary and appropriate, and conform to professionally- accepted standards of care. The following table of benefits include commonly used services. For a complete list of available benefits, refer to the following documents as appropriate:

- UPHP Member Handbook: A guide to your UPHP benefits https://www.uphp.com/medicaid/importantdocumentsforms/
- MI Health Link (MHL) Member Handbook https://www.uphp.com/medicare/uphp-mi-health-link/member-handbook/

Additionally, limits, notifications, and prior authorizations (PAs) may apply. For a comprehensive list of services that currently require notification or PA, please refer to UPHP's Prior Authorization/Notification Grid at https://www.uphp.com/providers/authorization-process/.

	Medicaid	HMP	MHL
Ambulance and other emergency medical transportation	X	X	X
Anesthesia	X	X	X
Bariatric surgery	X	X	X
Behavioral health services	X	X	X
Chiropractic services	X	X	X
Dental services	X	X	X
Diagnostic lab, x-ray and other imaging services	X	X	X
Durable medical equipment, supplies, orthotics, and prosthetics	X	X	X
Emergency services	X	X	X
End-stage renal disease services	X	X	X
Family planning services	X	X	X
Health education	X	X	X
Hearing aids	X	X	X
Hearing and speech services	X	X	X
Home health services	X	X	X
Immunizations	X	X	X
Inpatient and outpatient hospital services	X	X	X
Long-term support and services			X
Non-emergent medical transportation	X	X	X
Nursing facility services	X	X	X
Obstetric & maternity care	X	X	X
Occupational therapy	X	X	X
Office visits	X	X	X
Pharmacy services	X	X	X
Physical therapy	X	X	X
Podiatry services	X	X	X
Preventive care and screening	X	X	X
Respiratory care	X	X	X
Restorative or rehabilitative services	X	X	X
Specialist visits	X	X	X
Telemedicine	X	X	X
Therapy evaluation	X	X	X
Tobacco cessation treatment	X	X	X
Transplant and immunosuppressive drugs	X	X	X
Treatment for sexual transmitted infections	X	X	X
Urgent care visits	X	X	X
Vision services	X	X	X
Wellness services	X	X	X

Emergency Services

UPHP provides coverage/payment for emergent/urgent services without the requirement of prior authorization for both in-network and out-of-network providers, acknowledging the "prudent layperson" standard. UPHP considers the member's presenting symptoms when determining if the definition of "prudent layperson" is met. The attending emergency physician or treating practitioner determines when the member is stabilized sufficiently for transfer or discharge. UPHP will not deny payment for treatment of an emergency medical condition if a representative of UPHP instructed the member to seek emergency services.

UPHP does not deny any emergency department claims.

Transportation

Non-Emergent MedicalTransportation

UPHP provides non-emergent medical transportation (NEMT) to medically necessary, covered medical appointments and services for UPHP Medicaid, Healthy Michigan Plan (HMP), Children's Special Health Care Services (CSHCS), and MI Health Link (MHL) members. UPHP provides NEMT via mileage reimbursement or transportation. Mileage reimbursement is available for members who have a vehicle, or a friend, family member or neighbor willing to transport them. Transports are available for members who do not have a vehicle or someone to transport them. Transportation assistance can be arranged in the form of bus, cab, or volunteer drivers, and is arranged using the most cost- effective means that meets the member's medical need(s).

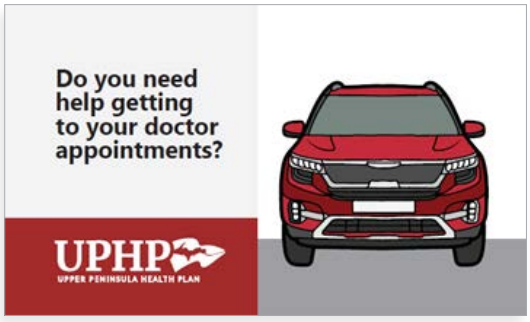
Members can submit mileage reimbursement request forms in the mail or by submitting online at www.uphp.com/transportation. Members can request transportation assistance using UPHP's online request tool at www.uphp.com/transportation or calling UPHP Transportation at 1-800-835- 2556 for any additional questions. For more information, including the transportation rules visit www.uphp.com/transportation.

Transportation Business Cards

Members missing appointments, frequently rescheduling, "no-showing," or having trouble obtaining medical services due to a lack of transportation should be directed to contact UPHP Transportation to review their benefits.

UPHP offers transportation education cards for provider offices to distribute to UPHP Medicaid, HMP, CSHCS, and MHL members who may need assistance getting to their appointments.

UPHP has cards targeted to medical and dental appointments as eligibility is different for each.



Providers wishing to request cards can email UPHP Provider Relations at uphpproviderrelations@uphp.com or call 906-226-4285.

Quality Assessment and Improvement and Utilization Management Program

The Quality Assessment and Improvement and Utilization Management (QAI/UM) Program facilitates the safe, efficient, effective, and economical delivery of person-centered services throughout the Upper Peninsula Health Plan (UPHP) network. The QAI/UM Program processes incorporate functions to examine the multifaceted components of health care delivery, make recommendations where problems are identified, and implement interventions to improve the quality and safety of health care in accordance with federal, state, and accrediting agency standards. The program promotes an integrated approach to evaluate and improve medical, behavioral, and dental services delivered to members, manage health care resources, improve the processes and outcomes of care provided to members and assure appropriate, timely, and efficient utilization of services.

UPHP selects, prioritizes, and conducts quality improvement projects relevant to its members designed to achieve—through ongoing measurement and intervention— beneficial effects on health outcomes and member satisfaction. Examples of quality improvement projects include evaluation of service and benefit utilization rates, timeliness of referrals or treatment, quality of life indicators, completion of preventive screening, polypharmacy, and chronic condition outcomes. Multiple sources such as health risk assessments, medical record reviews, condition management programs, drug utilization reviews, claims, and chronic care improvement programs are used to execute the QAI/UM program. The QAI/UM program evaluation determines the quality, safety, and appropriateness of services and care for UPHP members. The QAI/UM program evaluation determines the quality, safety, and appropriateness of services and care for UPHP members and helps identify the most vulnerable members of the population for which it can design quality improvement activities.

The UPHP Management Committee delegates authority to the UPHP Medical Director and Chief Executive Officer (CEO) to ensure the QAI/UM program has the resources needed to meet its goals and to evaluate the program's progress towards goals.

A copy of the most recently completed QAI/UM Summary Report is available to providers, upon request.

UPHP UM Functions and Activities

The UPHP Medical Director is responsible for oversight of the UM program activities and integration with quality improvement, peer review, credentialing, and other clinical services functions, to ensure optimal efficiency and effectiveness as it relates to provider clinical practice patterns and the quality-of-care members receive.

UM involves the evaluation of medical necessity and cost-effectiveness of health care services delivered to members, using accepted, standardized UM criteria and methodologies to screen for benefit coverage and medical necessity in accordance with regulatory and accrediting standards, MDHHS/CMS requirements, and UPHP policies.

UM activities are incorporated into QAI processes to the extent possible. UM is considered integral to the quality of care and services in the respect that UM decisions must be congruent with optimal quality of care and services for UPHP members.

The following components are integral to the UM program:

- Clinical criteria, timelines, information, and communication for decisions and appeals: For detailed information on the UM decision-making process for the various UPHP products, refer to UPHP Policies 300-005, 600-305 and 800-305 Utilization Management Process, which is further outlined later in this chapter. For detailed information on the clinical appeals processes, refer to UPHP Policies 300-024, 600-324, 800-324 Member Appeals Related to Utilization Management Adverse Determinations.

- Evaluation of new technology: UPHP evaluates new health care services to ensure members have equitable access to safe and effective care using a systematic process to evaluate the inclusion of new medical technologies and the new application of existing technologies in the care of members. This includes medical and behavioral health procedures, pharmaceuticals, and devices. The communication and oversight of this process is in accordance with UPHP Policy 300-021 Review of New Medical Technology.

- Assessing experience with the UM process: Annually, UPHP assesses both provider and member satisfaction with the UM processes and the UM Program to identify and act upon any opportunities for improvement.

- Emergency services: Emergency services are provided without the requirement of preauthorization, acknowledging the "prudent layperson" standard. Members are not held financially liable for emergency department services, and service claims are not reviewed for medical necessity. All emergency services claims are paid in accordance with UPHP policy 300-022 and 800-022 Emergency Services.

- Procedures for pharmaceutical management: These management procedures address how to use the pharmaceutical management system including explanations of any limits or quotas, how prescribing practitioners must provide information in support of exception requests, and the process for generic substitution, therapeutic interchange, and step therapy protocols. Medication therapy management for Medicare members is an important component of this management process. Pharmaceutical management is more fully described later in this chapter. UPHP Policies 300-008, 300-009, and 300-025 are also located on our website at: www.uphp.com/pharmacy-policies.

- Ensuring appropriate utilization: To ensure the delivery of appropriate care to members, UPHP informs members, practitioners, providers, and UPHP employees that there are no incentives to encourage barriers to care and service. UPHP also performs utilization analysis to identify potential under- and over- utilization issues and implements a plan of action that identifies opportunities for improvement.

- Affirmative Statement about Incentives: UM decision making is based only on appropriateness of care and service and existence of coverage. UPHP does not reward practitioners or other individuals for issuing denials of coverage or services. There are no financial incentives for UM decision-makers to encourage decisions that result in underutilization.

- Behavioral health care: UPHP Medicare plans provide benefit coverage for inpatient and outpatient behavioral health services for its Medicare members consistent with Medicare requirements.

    - For UPHP Medicaid, behavioral health services are carved out of the managed care contracts by the State of Michigan with the exception of outpatient behavioral health visits. UPHP does not have a centralized triage and referral process for behavioral health services UPHP will review for availability of services in-network if there is a request for a member to see an out-of-network provider.

Practitioner peer review is used to determine provider performance against UPHP CAC-approved standards of care. Some aspects of the review involve service site and access, use of diagnostic procedures, and coordination of transfers or changes in service sites when other sites/services are more appropriate. Peer review activities are considered confidential and subject to protection under the Michigan Release of Information for Medical Research and Education Act (MCLA Section 331.531 et seq.)

Data integrity evaluation ensures that the data used in QAI/UM activities is accurate, timely, complete, and reliable. UPHP collects and integrates data from all components of its network in order to develop a comprehensive picture of member needs and utilization, including changes over time, so that it may improve member care. UPHP complies with all HIPAA requirements and privacy and security laws in regard to the collection, maintenance, and reporting of data.

UPHP Clinical Services provides quality data for credentialing and contract monitoring in accordance with UPHP Policy 200-018 Recredentialing. Pertinent clinical information is provided to the Credentialing Committee to ensure that all network providers meet and maintain established standards in accordance with CMS requirements and regulatory and accrediting standards.

The QAI/UM Program is evaluated annually by the UPHP CAC and the UPHP SAC to determine program effectiveness, compare activities to the program goals and objectives, and ensure improvements in the quality and safety of clinical care and services to the members. The report provides the basis for the revisions to the QAI/UM program and the work plan for the following year. QAI/UM evaluation results are available annually upon request by contacting Clinical Services at 906-227-5681.

The QAI/UM work plan identifies annual quality and utilization goals and objectives, including the following information relative to the activities planned to reach each objective: target goals, planned interventions, time frames, and responsible individuals. The work plan includes planned monitoring of previously identified issues as delineated in the annual program evaluation and provides a mechanism to track issues for closure and timeliness.

Use of member information is restricted to purposes directly related to the administration of the services required under the contract, or release required by law. This is further described in related UPHP policies 104-007 Confidentiality of Information and 104-015 Disposal of Protected Health Information. Information required to study behavioral health shall be protected as is required by law. Information required to study and evaluate the quality of care and services, including cost-effectiveness, is made available only to those on a need-to-know basis who are active participants in the review process.

UPHP may delegate and/or coordinate QAI and/or UM activities with another health care entity using a mutually agreed upon document which describes the roles and responsibilities of UPHP and the delegated and/or coordinating organization. Prior to delegation, UPHP evaluates the agency's capacity to perform the activities, assigns responsibilities, determines methods of semi-annual reporting and performance monitoring, and the consequences of failure to perform according to the agreement.

Care Management Services

Upper Peninsula Health Plan (UPHP) Care Management is designed to meet the comprehensive medical, behavioral, and social determinant needs of UPHP members while promoting quality and cost-effective outcomes. The different care management programs support a collaborative process of assessing, planning, facilitating, coordinating, evaluating, and advocating for options and services for UPHP members. The goal is to help members maintain or regain optimum health or improved functional capability in the least restrictive setting and in a cost-effective manner through a person-centered process utilizing supportive self-management plans. UPHP honors member choices about their level of participation in assessments, care coordination activities, and care plan development. Care Management complements the primary care provider's (PCP) plan of care to help members to better manage their individual complex conditions. Clinical Coordinators' interventions include:

- Care coordination between providers.
- Individualized plans of care with short-term and long-term goals.
- Care coordination between providers and community organizations.
- Arranging referrals to providers and community resources.
- Transportation help when needed.
- Telephone, face to face, and video conferencing outreach to members.
- Integrated care team meetings.
- Assistance through transitions in care.
- Member education utilizing various modalities.

To identify if your member has a care manager working with them or to refer a member to care management, providers can call UPHP at 800-835-2556. To refer a member, you may also complete the Clinical Services Care Coordination/Care Management Referral Form and fax it to our office. The form is available for download on the UPHP website at http://www.uphp.com or by calling UPHP.

Utilization Management Process

Upper Peninsula Health Plan (UPHP) uses an integrated approach to coordinate and promote optimal utilization of health care resources, make utilization decisions that affect the health care of members in a fair, impartial, and consistent manner, and assist with the transition to alternative care when benefits end, should a member no longer be eligible for UPHP benefits.

Prior Authorization

Prior authorization (PA) decisions are made based on the determination of compliance with appropriate criteria. ***PA is required in order to receive payment for selected services.***

The below services and items require PA:

- Out-of-network services:
    - Practitioner services
    - Facility services
    - Laboratory services
    - Durable medical equipment (DME) and supplies
    - Planned (elective) inpatient admissions

- Chiropractic visits exceeding 18 visits per calendar year
- Genetic and molecular testing*
- Home health services beyond 90 days (MHL only)
- Medically-necessary weight reduction services
- Medically-necessary reconstructive surgery
    - Reduction mammaplasty
    - Panniculectomy
- Medical pharmacy (J codes)
- Physical and occupational therapy exceeding 144 units per calendar year (UPHP Medicaid Product Lines only)
- Speech therapy exceeding 36 visits per calendar year (UPHP Medicaid Product Lines only)
- Medical services/supplies not meeting CMS/MDHHS guidelines
- Durable medical equipment*
    - Bi-Pap/CPAP
    - Continuous glucose monitors
    - Hospital bed (semi-electric and total electric)
    - Miscellaneous DME and orthotic and prosthetic codes
    - Negative pressure wound therapy
    - Osteogenic bone stimulator
    - Pneumatic compression
    - Power wheelchairs/accessories
    - Speech generating devices
    - TENS units
    - Ventilator
    - Wearable cardioverter-defibrillators
    - Electrical stimulation devices used for cancer treatments (UPHP Medicaid Product Lines only)

* Please go to https://www.uphp.com/providers/authorization-process/ to view HCPCS/CPT codes that require PA.
** Please go to https://www.uphp.com/pharmacy/medicaldrugbenefitjcode/ to view J Codes that require PA.

UPHP does not require PA for urgent/emergent services.

Notification

Notification is required to receive payment for services. However, notification does not involve the application of clinical criteria for an authorization decision. Notification is required to trigger necessary care management activities on the part of UPHP. Services that require notification to UPHP Clinical Services include but are not limited to:

- In-network inpatient admissions and observation services – within one business day of admission (MHL only).
- Out-of-network urgent/emergent inpatient admissions/observation services- within one business day of admission.
- Skilled nursing facility/swing bed admissions – within one business day of admission.
- Long-term care admissions (MHL only) – within one business day of admission.

Please note that PA/notification requirements are subject to change. For full details on PA and notification requirements for UPHP, please go to https://www.uphp.com/providers/authorization-process/.

Prior Authorization/NotificationProcess

The process for PA or notification is as follows:

- Provider verifies:
    - Patient is currently a UPHP member.
    - Service request is for a UPHP covered benefit.
    - Service request requires PA or notification.
- Provider submits in writing by UPHP Assist Provider Portal (preferred for PA requests), fax (preferred for notifications), phone or mail:
    - UPHP Assist Provider Portal: https://assist.uphp.com
    - Appropriate Prior Authorization/Notification Request Form; UPHP forms are available from UPHP Customer Service or the UPHP website at https://www.uphp.com/providers/authorization-process/.
    - Clinical information to support the request as indicated on the form.

Authorization does not guarantee payment. All authorized items and services are subject to review for medical necessity, member eligibility, member plan benefits, and provider eligibility for payment at the time of service.

UPHP Time Frames for Authorization Requests

- For urgent, pre-service decisions, UPHP makes decisions within 72 hours of receipt of therequest.
- For non-urgent pre-service decisions, UPHP makes decisions within 14 calendar days of receipt of the request.

An extension of the timeframes up to 14 calendar days is allowed under the following circumstances:

- The member requests the extension.
- UPHP justifies a need for additional information and documents how the delay is in the best interest of the member.
- The extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the member's interest.

Providers will be notified by fax of the UM decision. For denials, the referring provider will receive a copy of the denial letter sent to the member including appeal rights.

If you have any questions or need assistance, please contact UPHP Utilization Management at:

Toll Free: 800-835-2556 (TTY: 711)

Direct UM Line: 906-225-7774

UM Fax Line: 906-225-9269

UPHP Transition of Care Program

UPHP has a Transition of Care program for UPHP Medicaid (MI Child, Healthy Michigan Plan (HMP), and Children's Special Health Care Services (CSHCS)) members who are newly enrolled with UPHP to ensure they do not experience any disruption in care. This care could include:

- Out-of-network providers/services
- Durable Medical Equipment/Medical Supplies
- Medications

UPHP has a designated Interdisciplinary Transition of Care team who can assist in assessing members' medical, behavioral health, dental, social needs, and prescriptions. Members must have seen their provider at least once within the last six months prior to UPHP enrollment and/or have been on a maintenance drug. UPHP will cover any services/providers/ medications for at least 90 days. The more detail that can be provided regarding the member's care and health needs, the better UPHP will be able to assist. This information includes provider names, contact persons, phone numbers, service types and appointment dates (if applicable). To request continued care, members, their authorized representatives, or providers can contact UPHP by writing or calling:

Upper Peninsula Health Plan
Attn: Utilization Management
853 West Washington Street
Marquette, MI 49855

Phone: Toll Free 1-800-835-2556 (TTY: 711)
Direct UM Line: 906-225-7774 Fax: 906-225-9269

Claims

Electronic Claims Submission

Upper Peninsula Health Plan (UPHP) accepts and encourages all providers to submit claims electronically, including secondary claims. Electronic claims will be submitted using the following information:

National Electronic Insurance Code (NEIC) # **38337**

UPHP also has a secure provider portal that can be used to submit claims directly to UPHP via direct claim entry or 837 claim file upload. You can also use the portal to status claims or discuss claim issues by direct messaging with our claims services representatives. For access, visit the UPHP website at www.uphp.com and select "Login" on the homepage. For EDI claim submission issues, please contact UPHP Claims at 800-835-2556.

Billing Address:
Upper Peninsula Health Plan
Attn: Claims
853 West Washington Street
Marquette, MI 49855

Please contact UPHP Claims for claims questions at 800-835-2556, Monday through Friday from 8 a.m. to 5 p.m. Eastern Time. Please have the member identification (ID) number, date of service, charge amount, and/or claim number ready when calling to ensure timely assistance.

Provider Registration

All ordering/referring and rendering/attending providers must be enrolled and active in the Michigan Medicaid program Community Health Automated Medicaid Processing System (CHAMPS) on the date of service to receive payment. Visit the Michigan Department of Health and Human Services (MDHHS) website for more information and instructions on registering in CHAMPS: https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/Medicaid-Providers/champs-a

Failure to register in the Michigan Medicaid CHAMPS system will result in claim denials for in-network providers.

Claims for services rendered as a result of an order or referral must contain the name and individual National Provider Identifier (NPI) of the practitioner who ordered or referred the items or services. All practitioners who order/refer services for Michigan Medicaid beneficiaries must be enrolled/registered in the Michigan Medicaid program. In addition, for all institutional claims, the attending physician must be Medicaid-enrolled.

There are guidelines in place that state which provider specialties are allowed as an attending/ordering/referring provider based on claim type. Visit the Attending Provider Tips on the Michigan Department of Health and Human Services (MDHHS) website for a list of allowable provider types.

Claim Submission Guidelines

Filing Limit

- Claims, including corrected claims, must be sent to UPHP within 365 days from the date of service.
- UPHP responds to claims within the applicable state and federal processing guidelines. The claims determination will be reported to the provider on an Explanation of Payment (EOP)/Remittance Advice (RA).
- All claims received after the filing limit will be denied and members may not be billed.

Claim Forms

- Use a CMS 1500 form for professional services provided by physicians and non-physicians, durable medical equipment providers, laboratories, ambulances, etc.
- Use a UB-04 form for services provided by hospitals (inpatient/outpatient), home health and hospice agencies, skilled nursing facilities, dialysis facilities, Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC) and Tribal Health Centers (THC).

Paper Claim Submission Guidelines

- Must use original forms – faxed copies will not be accepted.
- Must be typewritten or computer generated – handwritten forms will not be accepted.
- Do not use highlighters, white-out, or any other markers on the claim.
- Avoid script, slanted, or italicized type, 12-point type is preferred.
- Do not use an imprinter to complete any portion of the claim form.
- Do not use punctuation marks or special characters.

- Do not submit medical records unless requested.
- Use a six-digit format with no spaces or punctuation for all dates (i.e. March 1, 2020, would be 030120).
- If you are submitting paper claims and would like to start submitting electronically, please contact the UPHP Help Desk at 906-225-6811 for assistance.

Claims Submission Guidelines for MI Health Link

- Submit claims with the UPHP Medicaid member ID number.
- Submit one claim to UPHP – upon receipt of the claim, UPHP will dually process UPHP Medicare as primary and UPHP Medicaid as secondary. Do not submit two claims.

Claims Policies

Adjudication

- UPHP adjudicates Medicaid claims according to the State of Michigan Health and Aging Services Administration (HASA) policies and procedures. Reference the Uniform Billing Guidelines, ICD-10 Diagnosis Code Book, CPT Code Book, HCPCS and MDHHS website at www.michigan.gov when submitting a claim.
- UPHP adjudicates MI Health Link claims according to CMS policies and procedures and State of Michigan (HASA) policies and procedures. Reference the Uniform Billing Guidelines, ICD-10 Diagnosis Codes, CPT Codes, and HCPCS codes when submitting a claim.
- UPHP adjudicates Medicare claims according to the Medicare claim payment rules and regulations. Reference the Uniform Billing Guidelines, ICD-10 Diagnosis Code Book, CPT Code Book, and HCPCS when submitting a claim.

Payment

Contracted and non-contracted providers will be paid for covered services according to the Medicare Fee Schedule or the Medicaid Fee Schedule, whichever is applicable, in effect at the time of service, or the billed charges, whichever is less, unless other arrangements have been made.

Corrected Claims

- To avoid rejection of duplicate submissions, submit your entire corrected claim, not just the line items that were corrected.
- Providers may resubmit claims with correction(s) and/or changes electronically, by paper or direct claims entry via the UPHP provider claims portal.
- For electronic CMS 1500 claims, enter claim frequency type code in the 2300 loop, enter the original claim number in the 2300 loop in the REF*F8 and add a note explaining the reason for the resubmission in loop 2300 NTE (segment) ADD (Qualifier).
- For paper claims, populate box 22 with resubmission code 7 and the original claim ID number.
- For institutional claims, the type of bill must include the appropriate frequency.
- Corrected claims must be submitted within 365 days from the date of service.

National Drug Code (NDC)

Providers are required to report the National Drug Code (NDC) supplemental information in addition to the procedure code when billing for a physician administered drug. This requirement is mandated to ensure MDHHS compliance with the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148.

UPHP Required Fields:

CMS 1500	Required?	Field Location
Billing Provider NPI	Yes	Box 33a
Rendering Provider NPI	Yes	Box 24j
Referring Provider NPI	If Applicable	Box 17b
Facility Provider NPI	If Applicable	Box 32a
Taxonomy Code	If Applicable	Boxes 24j, 33b, and 32b

UB04	Required?	Field Location
Billing Provider NPI	Yes	Box 56
Attending Provider NPI	If Applicable	Box 76
Operating Provider NPI	If Applicable	Box 77j
Other Provider NPI	If Applicable	Box 78
Other Provider NPI	If Applicable	Box 79
Taxonomy	If Applicable	Boxes 57, 76, 77, 78, and 79

Coordination of Benefits

When a member has other insurance, there are rules set by Medicare that decide whether UPHP or the other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If the member has retiree coverage, Medicare pays first.
- If the member's group health plan coverage is based on their or a family member's current employment, who pays first depends on their age, the size of the employer, and whether they have Medicare based on age, disability, or end-stage renal disease (ESRD):
    - If the member is under 65 and disabled and they or their family member is still working, the employer plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
    - If the member is over 65 and they or their spouse is still working, the employer plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If the member has Medicare because of ESRD, the group health plan will pay first for the first 30 months after the member has become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for the Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

UPHP members should inform their providers, hospitals, and pharmacies of other insurance coverage and should update their other insurance information with UPHP. Any questions should be directed to UPHP Claims at 800-835-2556.

As a contracted provider treating members of UPHP, your cooperation in notifying UPHP when any other coverage exists is appreciated. This includes other health care plans or any other permitted methods of third-party payment. The Michigan Medicaid program is always the payer of last resort.

- Claims with coordination of benefits with primary insurance carriers should be received by UPHP within 365 days from the date of service.
- If UPHP reimburses a provider and then discovers other coverage is primary, UPHP will recover the amount paid by UPHP.
- Regardless of the primary payer's reimbursement, UPHP should be billed as the payer of last resort for all services rendered. A copy of the primary payer's explanation of benefits showing payment or denial must be attached to the claim when submitting on paper, or the claim can be submitted electronically for secondary consideration.
- UPHP will only make a payment if the primary insurance payment is less than the applicable UPHP payment up to the charge amount, whichever is less.
- UPHP Medicaid and MI Health Link members must not be billed for any outstanding balance after UPHP makes payment.
- UPHP Medicaid and MI Health Link members do not have deductibles or coinsuranc

Billing Reminders

- Do not continue to bill if you are unclear why an initial claim was rejected.
- Contact UPHP Claims for clarification.
- Facility billing must match physician billing.
- All same day services by the same physician for the same condition must be reported on one claim.
    - Do not split claims when E/M services are performed with any other service(s) i.e. vaccines, laboratory services and diagnostic testing
- Bill modifiers per CPT and HCPCS guidelines.
- UPHP Medicaid/MI Health Link (MHL) members cannot be balance billed for services. Balance billing is prohibited under your UPHP Participation Agreement and MDHHS Guidelines. Patient responsibility balance should reflect a $0 charge.
    - Members cannot be billed for the difference between the amount billed by the provider and the amount paid by UPHP.
    - Medicaid-covered services (providers must inform the beneficiary before the service is provided if Medicaid does not cover the service).
    - Medicaid-covered services for which the provider has been denied payment because of improper billing, and failure to obtain prior authorization.
    - If a member misses a scheduled appointment, provider offices cannot bill UPHP for the missed appointment.

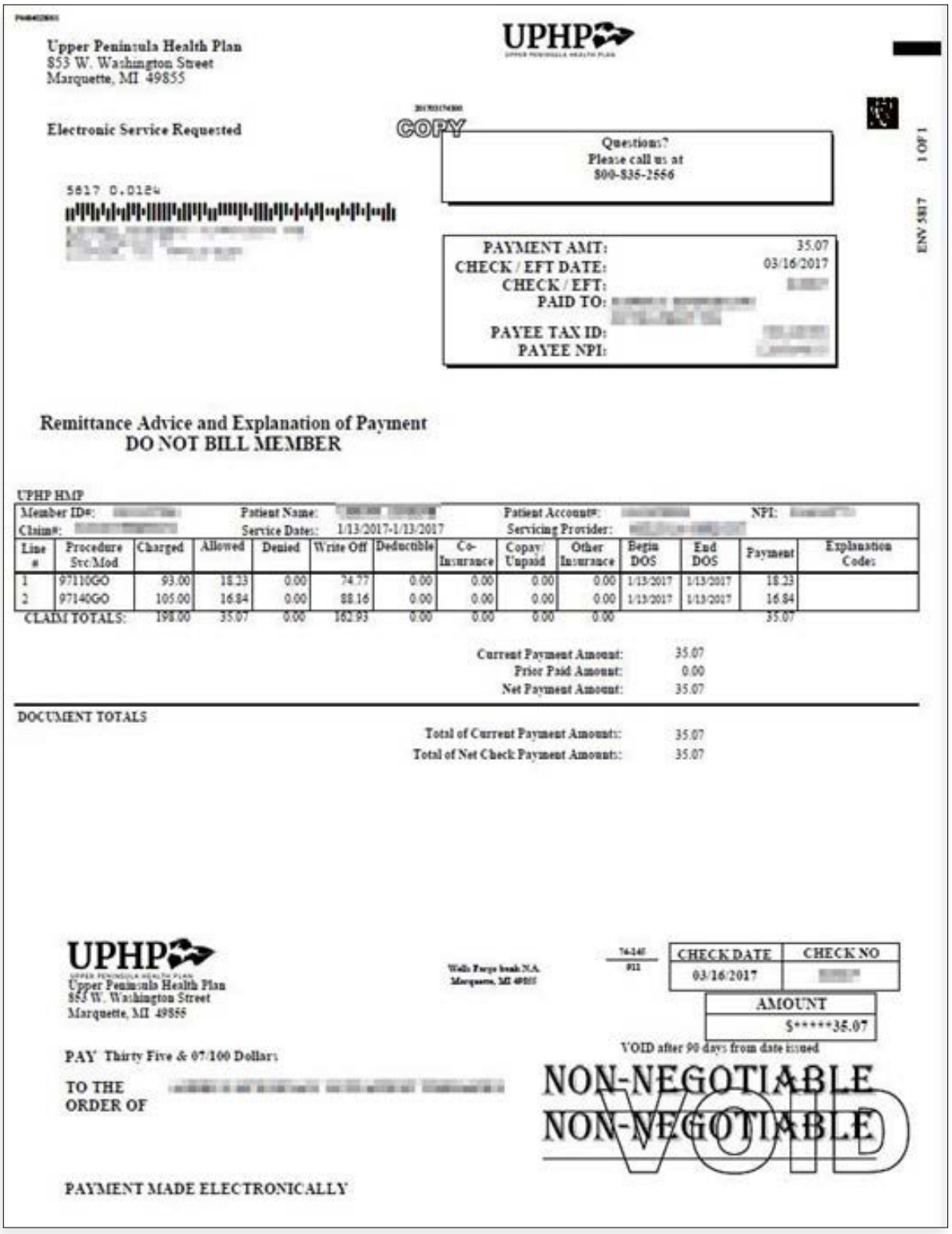
For further questions, please contact UPHP Claim Services at (906) 225-7746 or ClaimServices@uphp.com, or visit MedicaidProviderManual.pdf (state.mi.us) regarding billing.

Medicaid Billing Tools

The following list includes helpful tools that are highly recommended for each biller/coder to use on a daily basis:

- Michigan Medicaid Provider Manual – This manual gives detailed instructions on Michigan Medicaid benefits.
- CHAMPS – Medicaid Code and Rate Reference – This tool contains the most current fees with diagnosis and unit limits as well as billing guidelines. It should be checked regularly for changes, updates, and revisions.
- Health and Aging Services Administration Bulletin Updates – these updates indicate benefit, procedural, or reimbursement changes.

Sample Remittance Advice (RA)



Upper Peninsula Health Plan
853 W. Washington Street
Marquette, MI 49855

UPHP

Electronic Service Requested

COPY

Questions?
Please call us at
800-835-2556

5817 0.0184

ENV 5817 1 OF 1

PAYMENT AMT: 35.07
CHECK / EFT DATE: 03/16/2017
CHECK / EFT:
PAID TO:
PAYEE TAX ID:
PAYEE NPI:

Remittance Advice and Explanation of Payment
DO NOT BILL MEMBER

UPHP HMP

Member ID#: Patient Name: Patient Account#: NPI:
Claim#: Service Date: 1/13/2017-1/13/2017 Servicing Provider:

Line #	Procedure Src:Mod	Charged	Allowed	Denied	Write Off	Deductible	Co-Insurance	Copay Unpaid	Other Insurance	Begin DOS	End DOS	Payment	Explanation Codes
1	97110GO	93.00	18.23	0.00	74.77	0.00	0.00	0.00	0.00	1/13/2017	1/13/2017	18.23	
2	97140GO	105.00	16.84	0.00	88.16	0.00	0.00	0.00	0.00	1/13/2017	1/13/2017	16.84	
CLAIM TOTALS:		198.00	35.07	0.00	162.93	0.00	0.00	0.00	0.00			35.07	

Current Payment Amount: 35.07
Prior Paid Amount: 0.00
Net Payment Amount: 35.07

DOCUMENT TOTALS

Total of Current Payment Amounts: 35.07
Total of Net Check Payment Amounts: 35.07

UPHP
Upper Peninsula Health Plan
853 W. Washington Street
Marquette, MI 49855

Wells Fargo bank N.A.
Marquette, MI 49855

74-240
/12

CHECK DATE	CHECK NO
03/16/2017	

AMOUNT
$*****35.07

VOID after 90 days from date issued

PAY Thirty Five & 07/100 Dollars

TO THE ORDER OF

NON-NEGOTIABLE
NON-NEGOTIABLE VOID

PAYMENT MADE ELECTRONICALLY

Provider Claim Appeals

When a provider disagrees with a claim determination made by UPHP regarding payment for Medicare and/or Medicaid-covered services, they may file an appeal in writing to UPHP within 60 calendar days from the remittance notification date. UPHP may allow more time to file the appeal if the provider has good reason for missing the timeframe. UPHP will issue its reconsidered determination in writing and mail the determination no later than 60 calendar days from the date UPHP received the request for payment reconsideration. UPHP uses designated persons who were not involved in the making of the initial organization determination when reviewing reconsiderations. If the denial is based on lack of medical necessity, the reconsideration is reviewed by a physician with expertise in the field of medicine that is appropriate for the services at issue. An inquiry is not subject to the appeals process.

To file an appeal, the provider must have submitted a claim for the service and/or supplies in question and received a denial or reduction in payment from UPHP. The provider must submit a written request explaining the basis for the appeal to UPHP which includes the following:

- Member name
- Member identification number
- Remittance notification showing the denial
- Signed Waiver of Liability Form (required for non-contract providers appealing Medicare-covered services)
- Supporting documentation, such as proof of timely filing, medical records, reason for not obtaining authorization, or other information that supports the appeal or is pertinent to the appeal
- The name, address, and telephone number of the person responsible for filing the appeal

All provider appeal requests are to be mailed or faxed to:

Upper Peninsula Health Plan
Attn: UM Review and Appeals Coordinator
853 West Washington Street
Marquette, MI 49855
Fax: 906-225-7720

If UPHP does not receive the required documentation within 60 calendar days of UPHP receipt of appeal request, the request for appeal will be dismissed. UPHP will send written notification of the dismissal.
UPHP will outreach via phone and in writing to the appealing party to obtain the needed information prior to dismissal.

UPHP will process the appeal request and provide a written response within 60 calendar days. This is the final decision and appeal level for UPHP contracted providers. There are additional appeal levels for non- contracted providers depending on if the service is covered by Medicare or Medicaid as described below:

Medicare-covered Services

For non-contracted providers, if UPHP continues to deny payment in whole or in part for Medicare- covered services, UPHP will auto-forward the complete appeal case file to the Independent Review Entity (IRE) contracted by the Centers for Medicare and Medicaid Services (CMS) no later than 60 calendar days from the date UPHP receives the request for reconsideration.

When the IRE completes its reconsidered determination, it is responsible for notifying the involved parties of the reconsidered determination and informs parties, other than the health plan of their right to an administrative law judge (ALJ) hearing if the amount in controversy meets the appropriate threshold requirement and the decision is adverse. The IRE will describe the procedures that the parties must follow to obtain an ALJ.

If the amount in controversy meets the monetary threshold of the reconsideration, the provider may request an ALJ hearing within 60 days of receipt of the IRE reconsideration decision. This is the third appeal level. The IRE is responsible for compiling the reconsideration file and forwarding it to the appropriate ALJ hearing office. The provider must send a copy of the ALJ hearing request to all other parties to the reconsideration. Hearing preparation procedures are set by the ALJ. UPHP may become a party to, or participate in, an ALJ hearing after providing notice to the ALJ and the parties to the hearing. The ALJ will generally issue a decision within 90 days of receipt of the hearing request. This timeframe may be extended for a variety of reasons including, but not limited to the case being escalated from the reconsideration level, the submission of additional evidence not included with the hearing request, the request for an in-person hearing, the provider's failure to send notice of the hearing request to other parties, and the initiation of discovery if CMS is a party. If the ALJ does not issue a decision within the applicable timeframe, the provider may ask the ALJ to escalate the case to the Appeals Council level.

If the provider is dissatisfied with the ALJ decision, the provider may request a review by the Medicare Appeals Council (MAC), which is the fourth level of appeal. A minimum monetary threshold is not required to request Appeals Council review. The request must be submitted in writing within 60 days of receipt of the ALJ decision or dismissal and must specify the issues and findings that are being contested. In general, the Appeals Council will issue a decision within 90 days of receipt of a request for review. That timeframe may be extended for various reasons, including but not limited to, the case being escalated from an ALJ hearing. If the Appeals Council does not issue a decision within the applicable timeframe, the provider may ask the Appeals Council to escalate the case to the Judicial Review level.

If the MAC adopted, modified, or reversed the ALJ decision and the amount in controversy meets the appropriate threshold, the provider may request judicial review in federal district court. This is the fifth and final level of appeal. Information regarding this level of review is provided by the MAC.

Medicaid-covered Services

If a hospital disagrees with the UPHP reconsideration, they may submit a request to the Michigan Department of Health and Human Services (MDHHS) for Rapid Dispute Resolution. UPHP must comply with the Hospital Access Agreement for any non-contracted hospital providers. This applies solely to disputes with non-contracted hospital providers that have signed the Hospital Access Agreement. Non-contracted hospital providers that have not signed the Hospital Access Agreement and non-hospital providers do not have access to the Rapid Dispute Resolution process.

When a non-hospital provider or hospital provider that has not signed the Hospital Access Agreement requests arbitration, UPHP will participate in a binding arbitration process. Providers must exhaust the UPHP internal provider appeal process before requesting arbitration. To request arbitration, non-contract providers must send a written request to:

Upper Peninsula Health Plan
Attn: UPHP General Counsel- Arbitration Request
853 W. Washington Street
Marquette, MI 49855

MDHHS will provide a list of neutral arbitrators available to resolve billing disputes. These arbitrators will have the appropriate expertise to analyze medical claims and supporting documentation available from medical record reviews and determine whether a claim is complete, appropriately coded, and should or should not be paid. The party found to be liable will be assessed the cost of the arbitrator. If both parties are at fault, the cost of the arbitration will be apportioned.

Member Appeals

When an adverse benefit determination is made, a written notice is provided to the member and/or their authorized member representative, with a copy to the requesting provider, if applicable. This notice is written in an easily understandable language and states the reason for the adverse benefit determination and appeal rights.

Members or their authorized representatives may file an appeal with any UPHP employee orally or in writing 60 days from the date of notification of an adverse determination. Members may designate an authorized representative to act on their behalf using the UPHP Appointment of Representative (AOR) Form. An appeal request submitted by someone other than the member, including a provider (except for expedited appeals), is not considered received without an AOR. The AOR must be submitted within the 60-day appeal time frame. The UPHP response time frame will begin on the date the signed AOR is received. The AOR is also provided in the denial notice.

UPHP does not take any punitive actions against providers who request an expedited appeal or support a member's appeal.

UPHP has trained staff available to help with the appeal filing process. For assistance, contact UPHP Customer Service. UPHP also provides interpreter services and TTY/TDD toll-free numbers. Contact information is available below under "Filing an appeal with UPHP".

Upon receiving an appeal request, UPHP will provide the member, provider, or authorized representative reasonable opportunity, in person and in writing, to present evidence and testimony, and make legal and factual arguments. The appealing party has the right to submit comments, documentation, or other supportive information relative to the appeal. UPHP will inform the appealing party of the limited time available for this in advance of the resolution timeframe for the appeal in the case of expedited appeals.

An individual(s) not involved in the initial determination and not subordinate to any person involved in the initial determination will review the appeal. For medical necessity appeals or an appeal that involves clinical issues, the appeal will be reviewed by a practitioner of the same or similar specialty having appropriate clinical expertise in treating the member's condition or disease and not subordinate to a prior deciding practitioner.

The appealing party will be notified of the determination referencing the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision is based. This notice will also include a list of titles and qualifications, including specialties, of individuals participating in the appeal review. This is provided in an easy-to-understand, culturally linguistic, and appropriate manner.

Upon request, the member, provider, or authorized representative can obtain a copy of the actual benefit provision and guideline or criteria on which the appeal decision was based free of charge by contacting UPHP Customer Service. The member is also entitled to receive, upon request, reasonable access to and copies of all documents relevant to the member's appeal.

UPHP resolves each appeal and provides notice as expeditiously as the member's health condition requires.

The following sections describe the appeals process for each UPHP product line:

UPHP Medicaid, MI Child, Healthy Michigan Plan, Children's Special Health Care Services

A member, member-authorized representative, or a health care provider acting on behalf of the member with the member's written consent, may submit an appeal. Members can designate an authorized representative using the UPHP Appointment of Representative Form available on UPHP's website at https://www.uphp.com/medicaid/reportproblemsandappealdecisions/ or by calling UPHP Customer Service.

Filing an Appeal with UPHP

A member appeal may be initiated by writing or calling:

Upper Peninsula Health Plan
Attn: UM Review and Appeal Coordinator
853 West Washington Street
Marquette, MI 49855
Toll Free: 800-835-2556 (TTY: 711)
Fax 906-225-7720

Appeals will be handled and processed within the timeframes listed below.

Type of Appeal	Timeframe to Appeal	Appeal Decision
Standard	60 calendar days from the date of the denial notification letter	Within 30 calendar days from UPHP receipt of appeal request
Expedited Appeal	10 calendar days from the date of the denial notification letter	Within 72 hours of UPHP receipt of appeal request

UPHP will expedite appeals in which a standard resolution time frame would jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function. If a physician supports the member's request for an expedited appeal, UPHP will process as expedited. If UPHP denies the request for an expedited appeal, UPHP will transfer the appeal to a standard appeal timeframe and give member written notice of the denial within two days of the expedited appeal request.

UPHP may extend the timeframes for an appeals resolution for up to 14 calendar days if the member or member's authorized representative requests the extension.

Continuation of Benefits

UPHP must continue member benefits during the appeal process (including external appeal or State Fair Hearing) if all the following conditions apply:

- The member files the request for an appeal timely (within 60 calendar days of notification of the denial).
- The appeal involves the termination, suspension, or reduction of a previously authorized service.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not expired and the member timely files for continuation of benefits, meaning on or before the later of the following:
    - Within 10 days of UPHP mailing the adverse determination notice
    - The intended effective date of UPHP's proposed adverse determination notice

UPHP must continue the member's benefits while the appeal or State Fair Hearing is pending if the member files an appeal or request for State Fair Hearing within the specified timeframes for filing. Benefits must be continued until one of the following occurs:

- The member withdraws the appeal or request for State Fair Hearing.
- The member fails to request a State Fair Hearing and continuation of benefits within 10 days after UPHP mails an adverse resolution to the member's appeal.
- A State Fair Hearing decision adverse to the member is made.
- The authorization expires or authorization service limits are met.

UPHP may recover the related costs during the appeals process and/or external appeal or State Fair Hearing if:

- The decision to deny service is upheld.
- The member withdraws the appeal
- The member fails to attend the hearing

State Fair Hearing

A member, member authorized representative, or health care provider acting on behalf of the member with the member's written consent, have the right to request a State Fair Hearing if UPHP issues an adverse appeal decision. State Fair Hearing forms are included with the appeal denial notice.. The State Fair Hearing must be requested within 120 days of the UPHP internal appeal denial determination.

Write to:

Michigan Office of Administrative Hearings and Rules
P.O. Box 30763
Lansing, MI 48909-9951

External Review

The member, member authorized representative, or provider on behalf of the member with the member's written consent, has the right to request an external review by the Department of Insurance and Financial Services (DIFS). The request must be submitted to DIFS no later than 127 days following the receipt of the UPHP internal appeal denial determination.

DIFS may allow an exception to the requirement to exhaust the internal appeal process if medical documentation supports the need for an expedited external review. The member must first request an expedited internal appeal. After filing an appeal with UPHP, the member has the right to request an expedited external review with DIFS.

DIFS-Office of General Counsel-Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

Courier/delivery:
530 W. Allegan Street, 7th Floor
Lansing, MI 49833
Fax: 517-284-8838

UPHP MI Health Link

A member, estate representative, member-authorized representative, or health care provider acting on behalf of the member with member's written consent may submit an appeal. Members can designate an authorized representative using the UPHP Appointment of Representative Form or the Appointment of Representative Form (CMS-1696) available by contacting UPHP Customer Service or on UPHP's website at https://www.uphp.com/medicare/uphp-mi-health-link/grievances-appeals/.

Filing an Appeal with UPHP

A member appeal may be initiated by writing or calling:

Upper Peninsula Health Plan
Attn: UM Review and Appeal Coordinator 853 West Washington Street
Marquette, MI 49855
Toll Free: 877-349-9324 (TTY: 711)
Fax: 906-225-7720

Appeals will be handled and processed within the timeframes listed below:

Type of Appeal	Timeframe to Appeal	Appeal Decision
Standard	60 calendar days from the date of the denial notification letter	Within 30 calendar days from UPHP receipt of appeal request
Expedited Appeal	60 calendar days from the date of the denial notification letter	Within 72 hours of UPHP receipt of appeal request
Request for Payment	60 calendar days from date of the denial notification	Within 60 calendar days from UPHP receipt of appeal request

UPHP will expedite appeals in which a standard resolution time frame would jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function. If a physician supports the member's request for an expedited appeal, UPHP will process it as expedited. If UPHP denies the request for an expedited appeal, UPHP will transfer the appeal to a standard appeal timeframe and give the member written notice of the denial within two days of the expedited appeal request.

UPHP may extend the timeframes for the resolution of an appeal for up to 14 calendar days if the member or member's authorized representative requests the extension.

Continuation of Benefits

For all prior approved non-Part D benefits that UPHP terminates or modifies, UPHP will continue to provide Medicare and Medicaid benefits pending completion of the UPHP internal appeal process, Medicare IRE process, external review filed under PRIRA, or Medicaid Fair Hearing when:

- The member files the request for an appeal timely (within 60 calendar days of notification of the denial)
- The services were ordered by an authorized provider
- The period covered by the original authorization has not expired; and the member timely files for continuation of benefits, meaning on or before the later of the following:
    - Within 10 days of UPHP mailing the adverse determination notice
    - The intended effective date of UPHP's proposed adverse determination notice

This means that such benefits will continue until one of the following occurs:

- the member withdraws the appeal or request for state fair hearing,
- the member fails to request a state fair hearing and continuation of benefits within 10 calendar days after the notice of adverse resolution or,
- the state fair hearing office/IRE issues a decision adverse to the member.

UPHP will continue to pay providers for providing such services pending the outcome of the appeal. Payments will not be recouped based on the outcome of the appeal for services covered during the pending appeals.

External Review

Once the UPHP internal appeal process has been exhausted, the appealing party has further appeal rights through Medicare and/or Medicaid depending on the service being appealed.

For Medicare-covered services:

If the UPHP internal appeal decision is partially favorable, adverse, or untimely, UPHP will automatically forward the member's appeal case file to the CMS IRE for reconsideration.

IRE timeframes:

Type of Appeal	Timeframe to forward to IRE	IRE Decision
Standard	Within 24 hours from internal appeal decision	Within 30 calendar days of receipt from UPHP
Expedited Appeal	6Within 24 hours from internal appeal decision	Within 72 hours of receipt from UPHP
Request for Payment	Within 60 calendar days from receipt of appeal	Within 60 calendar days of receipt from UPHP

If the IRE upholds the denial, the appealing party will be notified of further appeal rights available through the following entities:

- Third Level of Appeal - Administrative Law Judge
- Fourth Level of Appeal - Medicare Appeals Council
- Fifth Level of Appeal - Federal District Court

For Medicaid-covered services:

State Fair Hearing
A member, member authorized representative, or health care provider acting on behalf of the member with the member's written consent, have the right to request a State Fair Hearing if UPHP issues an adverse appeal decision. State Fair Hearing forms are included with the appeal denial notice. The State Fair Hearing must be requested within 120 days of the UPHP internal appeal denial determination. Write to:

Michigan Office of Administrative Hearings and Rules
P.O. Box 30763
Lansing, MI 48909-9951

External Review with DIFS
The member, member authorized representative, or provider on behalf of the member with the member's written consent, has the right to request an external review by the DIFS. The request must be submitted to DIFS no later than 127 days following the receipt of the UPHP internal appeal denial determination.

DIFS may allow an exception to the requirement to exhaust the internal appeal process if medical documentation supports the need for an expedited external review. The member must first request an expedited internal appeal. After filing an appeal with UPHP, the member has the right to request an expedited external review with DIFS.

DIFS-Office of General Counsel-Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

Courier/delivery:
530 W. Allegan Street, 7th Floor
Lansing, MI 49833
Fax: 517-284-8838

For services that may be eligible for both Medicare and Medicaid, the appealing party has the right to appeal through the external Medicare and Medicaid appeal process.

Grievances

UPHP Medicaid, Healthy Michigan Plan, Children's Special Health Care Services

A member, member-authorized representative, or a health care provider acting on behalf of the member with the member's written consent, may submit a grievance. Members can designate an authorized representative using the UPHP Appointment of Representative Form available on UPHP's website at https://www.uphp.com/medicaid/reportproblemsandappealdecisions or by calling UPHP Customer Service.

Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, failure to respect the member's rights, or a member's right to dispute an extension of time proposed by the health plan to make an authorized decision.

A member or their authorized representative can file a grievance by calling UPHP Customer Service or by writing us at:

Upper Peninsula Health Plan
Attn: Customer Service
853 West Washington Street
Marquette, MI 49855

UPHP will communicate by written notice any findings and/or determinations to the member or their authorized representative. The determination will be provided in a culturally and linguistically appropriate manner. Grievance determinations are made within 90 days of the receipt of the grievance or as expeditiously as the member's health condition requires.

If the member is dissatisfied with the final determination made by UPHP, he/she may be able to seek an independent (external) review with the Michigan Department of Insurance and Financial Services (DIFS) under the Patient's Right of Independent Review Act (PRIRA). Not all grievances are eligible for review. The member should contact DIFS to determine whether their grievance meets the requirements for review. The member has 127 days from the date of the UPHP final appeal determination notification to request an external review which must be made in writing and may contact them by:

Phone:	1-877-999-6442
Mail:	DIFS-Office of Consumer Services, P.O. Box 30220 Lansing, MI 48909-7720
Courier/delivery:	530 W. Allegan Street, 7th Floor Lansing, MI 49833
Fax:	517-284-8837

Email: difs-hicap@michigan.gov

Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

UPHP MI Health Link

A member, member-authorized representative, or a health care provider acting on behalf of the member with the member's written consent, may submit a grievance. Members can designate an authorized representative using the Appointment of Representative Form available on UPHP's website at https://www.uphp.com/medicare/uphp-mi-health-link/grievances-appeals/ or by calling UPHP Customer Service.

Grievances can be any complaint or dispute (other than one that involves an organization determination), expressing dissatisfaction with any aspect of UPHP or its provider operations, activities, or behavior, regardless of whether remedial action is requested.

A member or their authorized representative can file a grievance by calling UPHP Customer Service or by writing us at:

Upper Peninsula Health Plan
Attn: Customer Service
853 West Washington Street
Marquette, MI 49855

UPHP will communicate by written notice any findings and/or determinations to the member or their authorized representative as expeditiously as the member's case requires, based on the member's health status but no later than 30 calendar days from the date the oral or written request is filed with UPHP.

A timeframe of up to 14 calendar days may be granted if the member requests the extension or if UPHP shows there is a need for additional information and how the delay is in the interest of the member. If UPHP extends the timeframe for the grievance and it is not at the member's request, UPHP will make reasonable efforts to give the member prompt oral notice of the delay. Additionally, within two days, UPHP will give the member written notice of the reason for the extended timeframe and their right to file a grievance if he or she disagrees with that decision.

Expedited Grievances

Members or their representative have the right to request an expedited grievance if UPHP denies the request for an expedited organization determination or appeal, or when UPHP decides to take an extension on a request for an organization determination or appeal. In such cases, UPHP will make a determination and notify the member or representative within 24 hours. In addition, a letter stating the health plan's decision will be sent within three calendar days.

Quality of Care Grievances

Quality of care grievances may be acted upon by UPHP or through the Quality Improvement Organization (QIO). There is no filing time limit for grievances concerning quality of care. All quality-of-care grievances, whether submitted orally or in writing, will be responded to in writing. Grievances that are acted upon by UPHP are routed to the UPHP Medical Director for review. In addition, UPHP will send a letter to the member that will include information about the member's right to file the grievance with the QIO and the contact information for the appropriate QIO to which the member may submit his/her quality-of-care grievances.

External Grievances

If a member or their authorized representative is not satisfied with UPHP's resolution of a grievance, they may file an external grievance.

An external grievance is filed with and reviewed by an organization that is not connected to UPHP.

How to file an external grievance:

- A member can tell Medicare about their grievance. They can use the Medicare Complaint Form available online at www.medicare.gov/MedicareComplaintForm/home.aspx. Or, they can call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

- If a member needs help filing an external grievance, they can call the MI Health Link Ombudsman Program (MHLO) at 1-888-746-6456, Monday through Friday, 8 am to 5 pm. TTY users call 711.

- A member can file a grievance with the U.S. Department of Health and Human Services Office for Civil Rights if they think they have not been treated fairly. For example, they can file a grievance about disability access or language assistance. Call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. They can also visit www.hhs.gov/ocr for more information.

A member can tell the State of Michigan about their complaint:

If a member has a problem with UPHP, they can contact the Michigan Department of Insurance and Financial Services (DIFS) at 1-877-999-6442, Monday through Friday, 8 a.m. to 5 p.m. The call is free. They can also email difs-HICAP@michigan.gov, fax 517-284-8837, or write to:

DIFS – Office of Consumer Services
P.O. Box 30220
Lansing, MI 48909-7720

To file a complaint against a health care provider, a member can call 517-373-9196, go online at https://www.michigan.gov/lara/bureau-list/bpl/complaint or write to:

Michigan Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
Enforcement Division
P.O. Box 30670 Lansing, MI 48909
Email: BPL-Complaints@Michigan.gov

Pharmacy

The prescription benefit is an important component of comprehensive health care coverage for our members. UPHP's goal is to provide members with clinically appropriate and cost-effective pharmaceutical care.

UPHP contracts with Magellan Rx Management, a pharmacy benefit manager (PBM), to manage the MI Health Link, , and Medicaid, Healthy Michigan Plan, and Children's Special Health Care Services (CSHCS) formularies, as well as its pharmacy network.

Important Pharmacy Contact Information

Prescription Drug Coverage Determinations/Prior Authorizations (Magellan Rx Management)**:**

- UPHP Medicaid/Healthy Michigan Plan/CSHCS — Phone: 248-540-6686, Fax: 248-341-8133
- UPHP MI Health Link — Phone: 855-390-0275, Fax: 866-391-6730

General UPHP Formulary or member benefit coverage questions (UPHP Customer Service)**:**

- UPHP Medicaid/Healthy Michigan Plan/CSHCS — Phone: 800-835-2556
- UPHP MI Health Link — Phone: 877-349-9324

Medical Pharmacy Benefit questions:

- UPHP Assist Provider Portal (for submitting and viewing the status of prior authorization requests): https://assist.uphp.com/
- UPHP Fax (forms can be found on www.uphp.com): 906-225-4516
- UPHP Phone (for prior authorization questions): 906-232-1628
- Magellan Rx Phone (for post-service claim edit questions): 800-424-8241

General questions about Medicare prescription drug coverage can be directed to Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, seven days a week, or visit http://www.medicare.gov.

Formulary or Drug List

UPHP maintains up-to-date searchable formularies on its website at www.uphp.com/pharmacy. These formularies list covered medications and coverage limitations, such as prior authorizations (PAs), quantity limits and step therapies. All PAs must be obtained before a prescription will process. Step therapy requirements require that certain drugs must be tried in order for another drug to be covered.

Formularies can be searched alphabetically and by the therapeutic class of the medication. Use the alphabetical list to search by the first letter of a medication using either the generic or brand name. The search function can be used to determine coverage as well as alternative coverage.

Members receive detailed information regarding their plan-specific prescription drug coverage in their Evidence of Coverage, Member Handbook and/or other plan materials. If you have questions, you may contact UPHP Customer Service or Magellan Rx Management.

There are specific drugs that are covered as a **medical benefit** and require PA before services are provided in the following settings:

- Physician offices
- Outpatient facilities
- Home infusion

The medical pharmacy codes that require a PA can be found on the UPHP website at https://www.uphp.com/pharmacy/.

UPHP MI Health Link:

The UPHP MI Health Link formulary combines both Medicare and Michigan Medicaid benefits for members. The UPHP MI Health Link formulary is a two-tier formulary. Generic Drugs are Tier 1 and Brand Drugs are Tier 2. UPHP MI Health Link covers some over the counter (OTC) drugs when they are written as prescriptions by a provider. UPHP MI Health Link members have no copays for prescription and covered OTC drugs. UPHP MI Health Link must abide by Medicare Part D rules which include the requirement that prescription drugs must have a "medically-accepted indication," which is defined as any use of a covered Part D drug which is approved under the Federal Food, Drug, and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in the Act.

The UPHP MI Health Link formulary may change during the year. Generally, these changes only occur when:

- A less expensive drug becomes available that is as effective as a drug currently on the formulary.
- A drug is not safe.
- Data indicates it is necessary to alter a coverage limitation such as:
    - Require or eliminate PA requirements.
    - Add or change quantity limits.
    - Add or change step therapy requirements.

UPHP informs members at least 60 days before removal of a medication from the formulary or the addition of PA requirements, quantity limits, or step therapy restrictions for a medication they are taking.

Covered Drugs
UPHP MI Health Link covers all medically necessary drugs on the formulary when prescribed by the member's provider. These drugs are available at pharmacies within the UPHP network. A pharmacy is in-network when UPHP has an agreement with them to provide services. These pharmacies are referred to as "network pharmacies."

Drug Formulary Exceptions/Coverage Determination Process
An exception to UPHP coverage rules can be requested. An exception can be requested to cover a drug that is not on the formulary, to ask for an initial coverage decision for a formulary, tiering, or utilization restriction exception, to waive coverage restriction or limits on a drug, or to provide a higher level of coverage for a drug.

UPHP MI Health Link providers can contact Magellan Rx Management at 855-380-0275 for a coverage determination or access appropriate forms on the UPHP website at www.uphp.com/providers/forms- links.

The member, their appointed representative, or a provider/prescriber can submit a request for a coverage determination orally or by using the Request for Prescription Drug Coverage Determination Form. All necessary information should be completed on the form. It may be mailed or faxed to Magellan Rx

Management at the address listed on the form or Magellan Rx Management may be contacted directly at the toll-free number indicated on the form.

An adverse coverage determination constitutes any unfavorable decision made by or on behalf of UPHP MI Health Link regarding coverage or payment for prescription drug benefits a member believes he or she is entitled to receive.

A decision by UPHP MI Health Link concerning an exception request constitutes a coverage determination. Therefore, all of the applicable coverage determination requirements and timeframes apply. When an exception request is received, it can be pended until a provider submits the medical reason(s) for the drug exception. Providers may mail or fax the information or provide the information on the phone and follow up by faxing or mailing a written statement as noted on the Coverage Determination Form.

For more information about the coverage determination process, review the UPHP MI Health Handbook on the UPHP website.

UPHP MI Health Link have both a standard and expedited procedure in place for making coverage determinations. Generally, a request for an exception is only approved if the alternative drugs included on the UPHP formulary or additional utilization restrictions would not be as effective in treating a condition and/or would cause adverse medical effects. Members or their authorized representative may ask UPHP for a formulary or utilization restriction exception with a statement from their provider supporting their request. A decision is usually made within 72 hours of receiving the prescriber's supporting statement. An expedited exception can be requested if it is believed that the member's health could be seriously harmed by waiting up to 72 hours for a decision. If an expedited request is granted, a decision will be provided to the member no later than 24 hours after receipt of the prescribing physician's supporting statement. The member, their appointed representative and provider are notified of the decision.

Transition Supplies
New members may be taking drugs that are not on the UPHP Medicare Part D formulary. When this occurs, UPHP covers transition supplies of these drugs. Please note that the UPHP transition policy applies only to those drugs that are "Part D drugs" and processed at a network pharmacy. The transition policy cannot be used to buy a non-Part D drug or a drug from an out- of-network pharmacy.

Providers can assist the member to switch to a similar, appropriate UPHP Medicare Part D formulary drug or request a formulary exception. During the first 90 days a member is in the UPHP MI Health Link, UPHP Advantage, or UPHP Choice plan, UPHP covers a maximum one-month supply transition fill, unless a prescription is written for fewer days, at network pharmacies.

If the member is a resident of a long-term care (LTC) facility, UPHP allows a refill of a prescription until a 91-day transition supply has been provided, consistent with the dispensing increment, unless a prescription is written for fewer days. UPHP covers more than one refill of these drugs for the first 90 days.

Medication Therapy Management Program

The Centers for Medicare and Medicaid Services (CMS) requires companies that offer Part D benefits to also offer a Medication Therapy Management Program (MTMP). This program is not considered a benefit and is a free service for eligible beneficiaries. Members who meet criteria are automatically enrolled in the program but have the ability to opt-out if they do not wish to participate. The program is administered by a team of health care professionals, including clinical pharmacists, registered nurses, case workers, and support staff.

The UPHP MTMP targets beneficiaries who:

- Have multiple specific chronic diseases; and
- Are taking multiple Part D drugs; and
- Are likely to incur specified annual cost thresholds OR
- Are determined to be an at-risk beneficiary (ARB)

UPHP and Magellan Rx Management manage the MTMP, which is offered to beneficiaries and prescribers. It is structured to meet CMS requirements and provide value-driven health care for Medicare Part D beneficiaries.

Upon identification of an MTMP-eligible member, Magellan Rx Management begins member outreach with a welcome letter sent to the eligible member within 60 days of identification. The welcome letter provides details of the program, an offer to schedule a Comprehensive Medication Review (CMR), and a description of MTMP options (i.e. level of participation, including the option to opt-out). Within 60 days of identification, Magellan Rx Management will also provide telephonic outreach to MTMP-eligible members. LTC beneficiaries are offered the same services as non-LTC members. LTC members receive a welcome letter and telephonic outreach to promote CMR participation.

CMRs are performed at least annually if the patient, caregiver, or other authorized individual elects to participate in the interactive review. MTMP-eligible members who choose not to participate in the CMR are provided a Targeted Medication Review (TMR). A TMR is performed quarterly for all active MTMP-eligible members, evaluating any inputs that are part of the MTMP.

The UPHP MTMP includes both member and prescriber-based interventions in accordance with the CMS expectations. Following a CMR, the CMS Standardized Cover Letter, Personal Medication List, and Medication Action Plan are mailed to all participating members. The prescriber of the eligible member receives a faxed physician CMR recommendation letter, which includes patient-specific subjective and objective clinical data, as well as pharmacist-identified recommendations from the CMR. At the discretion of the pharmacist, the prescriber may be contacted directly by telephone, in addition to receiving faxed information.

Additional information about the UPHP MTMP is available on the UPHP website, by calling UPHP Customer Service, or by calling the Magellan Rx Management Medication Therapy Management department directly at 800-424-9342 (TTY: 711). Hours of operation are Monday through Friday from 9a.m. to 5 p.m. Eastern Time.

UPHP Medicaid, Healthy Michigan Plan, and CSHCS:

For UPHP Medicaid, Healthy Michigan Plan, and CSHCS members, the UPHP formulary is aligned with the MDHHS Common Formulary for all contracted health plans in the State of Michigan per the Comprehensive Health Plan contract. The Common Formulary Workgroup, composed of representatives from contracted health plans, provides recommendations to MDHHS on drugs to be included on the Common Formulary. MDHHS has final approval authority for MDHHS Common Formulary coverage. The UPHP Medicaid formulary cannot be more restrictive than the coverage parameters of the MDHHS Common Formulary but may be less restrictive in some instances. The formulary is available on our website at https://www.uphp.com/pharmacy/ or by calling Customer Service at 800-835-2556.

Formulary Categories

The UPHP formulary includes drug utilization management tools such as PA criteria and step therapies. Coverage limitations including age edits, gender edits, and quantity limits are also used and noted in the formulary. The goal of the utilization management edits is to ensure that drugs are utilized in a medically-necessary, clinically-appropriate, cost-effective, and safe manner.

Formulary Preferred Medications: Medications in this category that may or may not require PA.

Step Therapy: Requires the use of a drug or drug class prior to utilization of these medications.

Formulary Non-Preferred Medications with PA: These medications may require the use of first-line or preferred medications before they are approved. Procedures to request a PA are included in this document.

Non-formulary Medications: Some medications can be considered for exception when formulary medications are not appropriate for a particular patient or formulary alternatives have been proven ineffective. A PA request, along with clinical evidence, must be provided and is taken into account when evaluating the request to determine medical necessity.

Drugs Available But Not Covered by UPHP (Carve-Outs): Selected drugs and classes are carved out from the managed care plan coverage and are paid directly to a pharmacy by the MDHHS Fee-For-Service program. Examples are behavioral health drugs and drugs used to treat HIV/AIDS. A complete list of carved-out medications is available at https://michigan.magellanrx.com/provider/documents. Pharmacies must bill Magellan Rx Management Medicaid Administration to receive reimbursement for these drugs.

Medications Not Covered by Medicaid: Certain medications are not covered under the Medicaid benefit and therefore are excluded from coverage. Examples are drugs used in the treatment of fertility or for cosmetic purposes. These exclusions are determined by MDHHS.

Medically Accepted Indications: Medically accepted indications are also considered for approval. Medically accepted indications include any use of a drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in the compendia listed in Section 1927(g)(I)(B)(i) of the Social Security Act.

Pharmacy Procedures: Information on UPHP pharmacy management procedures are described in detail in this provider manual and can also be found on the UPHP website at www.uphp.com/pharmacy. These policies and procedures are reviewed annually. To requesta hard copy of the procedures, call UPHP Customer Service. Providers without access to the website may request that information be mailed or faxed to them by calling UPHP Customer Service.

Copayments: Medicaid members have no copayments for medications. Healthy Michigan Plan members have no copayments at the point of sale.

Prior Authorization: UPHP encourages providers to prescribe within the UPHP formulary.

PA requests are generated at the prescriber level: The Request for Prior Authorization Form is available on the UPHP website at https://www.uphp.com/providers/forms-links/. A provider without access to the website may request that the form be mailed or faxed to them by calling UPHP Customer Service or Magellan Rx Management Customer Service.

PA is required for the following medications:

- Medications prescribed outside of quantity limits, time limits, and/or age restrictions.
- Medications prescribed outside of step therapy or preferred status.
- Non-formulary medications.
- Dispense as Written prescriptions when a generic equivalent is available.
- Non-preferred medications and certain preferred medications

PA Procedure

1. Primary Care Provider (PCP), specialist, or their designated agent completes the UPHP Request for Prior Authorization Form that can be found on our website at https://www.uphp.com/providers/forms-links/. The prescribing physician and beneficiary information must be complete, as well as the drug name, strength, administration schedule, length of therapy, and quantity requested. The prescriber may complete the remaining information by submitting a dictation, clinic notes, or a letter that contains the relevant information.

2. The form is faxed to Magellan Rx Management at the number listed on the Request for Prior Authorization Form. Forms are also accepted by mail. Prescribers may contact the PBM by telephone during regular business hours and verbally complete the Request for Prior Authorization Form if the situation is urgent or an emergency. A written form must follow. Any urgent requests will be processed as soon as possible. Every effort will be made to ensure urgent requests are answered on the same day of the request.

3. Upon receipt of the Request for Prior Authorization Form, an appropriate professional, based on PA criteria or medical necessity, reviews the request and supporting documentation using some or all of, but not limited to, the following criteria:
    - UPHP formulary guidelines.
    - FDA approved indications for the medication requests.
    - The member's diagnosis and/or the indication for use.
    - Previous drug treatment for the member's diagnosis.
    - Compliance with previous drug treatment(s).
    - Previous therapy failure using formulary alternatives.

4. If the request meets approved criteria as set forth by the MDHHS Managed Care Organization Common formulary or UPHP Pharmacy Clinical Advisory Committee, an approval is entered into the pharmacy claims system to allow the claim to process. If the authorization does not meet criteria based on the documentation provided or if a response is not received by the PBM in a timely manner, the request is denied. The provider is notified via fax by the PBM of all decisions. Requests may pend if more information is needed. The PBM will contact the prescriber to obtain complete information.

   Denied PA and medical necessity requests are processed in accordance with the UPHP Policy 300-005: Utilization Management Process, Policy 300-024: Member Appeals Related to Utilization Management Adverse Determinations, and National Committee for Quality Assurance and MDHHS Standards for timeliness and notification. A member, member-authorized representative or a health care provider acting on behalf of the member with the member's written consent, may submit an appeal. Members can designate an authorized representative using the UPHP Appointment of Representative Form available on UPHP's website at https://www.uphp.com/medicaid/reportproblemsandappealdecisions/ or by calling UPHP Customer Service.

Immunizations

UPHP providers are required to participate in the State of Michigan Immunization Initiatives, including documenting the administration of vaccines in the Michigan Care Improvement Registry. Providers are also required to cooperate in an annual review of participation in initiative programs and to provide immunizations that should be given in conjunction with well-child and Early and Periodic Screening, Diagnosis, and Treatment care when possible. Every office visit should provide an opportunity to assess immunization needs and vaccinate when appropriate. Medicaid providers are encouraged to participate in the Vaccines for Children Program.

Adult Medicaid Immunizations

- Michigan Medicaid provides reimbursement to providers who vaccinate eligible adults.
- All vaccines routinely recommended on the Centers for Disease Control and Prevention Adult Immunization Schedule.
- Providers must use private stock vaccine and bill Medicaid for the cost of the vaccine and vaccine administration fee.
- Medicaid policy, MSA 15-08, allows pharmacies to administer all Advisory Committee on Immunization Practices (ACIP) recommended vaccines to adults 19 years of age and older. For beneficiaries enrolled in a Medicaid Health Plan (MHP), pharmacy providers should confirm coverage of pharmacist-administered vaccines with the MHP by reviewing the UPHP formulary located on the UPHP website: https://www.uphp.com/pharmacy/.

  Source: https://www.michigan.gov/documents/mdhhs/Helping_Adults_Pay_Vaccine_514117_7.pdf

Adult Medicare Immunizations

Medicare Part B

- Allows for an annual influenza vaccine and two different pneumococcal vaccines (PCV13 and PPSV23).
- Allows for Hepatitis B vaccine for persons in certain high-risk groups and tetanus for wound care.
- For more billing information, visit https://www.cms.gov/medicare/payment/all-fee-service-providers/medicare-part-b-drug-average-sales-price/asp-pricing-files.

Medicare Part D

- Plans must cover all ACIP routinely recommended vaccines that are not covered under Medicare Part B, following Affordable Care Act (ACA) guidelines.
- Check with the insurance plan for specific coverage details.
- For more information: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/mln-publications-items/icn908764.

Credentialing

Upper Peninsula Health Plan's (UPHP) credentialing process is based on standards set forth by the National Committee for Quality Assurance (NCQA), the State of Michigan, and the Centers for Medicare and Medicaid Services (CMS). Applications for membership to UPHP's provider network shall be provided to Medical Practitioners and Behavioral Health Practitioners with whom it contracts or employs and who fall within its scope of authority and action.

Participation Criteria for Providers

All providers wishing to participate in the UPHP provider network must be credentialed in accordance with NCQA verification requirements and the company's policy.

Only those applicants who satisfy UPHP's credentialing criteria by providing a complete application, including supporting documentation and by cooperating with the Credentialing Committee through full and timely responses to all reasonable inquiries and investigations, shall be eligible to participate in the company's provider network.

Contracted providers may announce new or continuing affiliations with specific Plans and/or Part D sponsors once a contractual agreement between the plan/part D sponsor has been approved. UPHP will not limit or prohibit a provider's communication with enrollees of the provider's affiliation or change in affiliation.

All UPHP network providers must cooperate with UPHP's quality improvement activities to improve quality of care, services, and member experience. Cooperation may include, but is not limited to, the collection and evaluation of data and participation in UPHP's quality improvement programs. UPHP may use provider performance data for quality improvement activities.

Applicants have the right to review certain information obtained during the credentialing process, the right to correct erroneous information, the right to be informed of the application status, and the right to appeal any adverse decision of the Credentialing Committee regarding appointment or reappointment to the company's provider network.

All practitioners have a right to review the information obtained by UPHP used to evaluate the practitioner's credentialing application. This includes malpractice claims history, school or residency completion, license actions, board certification or affiliation history. The applicant does not have the right to review references, recommendations, peer-review information, information that is collected which is not obtained to meet verification requirements or any information in which the law prohibits it and shall never be revealed to the applicant. The practitioner may call or write the UPHP Credentialing Supervisor or the UPHP Medical Director to make an appointment to review his or her credentialing information.

Upon request, the UPHP Credentialing staff will inform a practitioner of the status of his or her application. The status may be given either verbally or in writing, within five business days of the request. Written notice may include returning application or contracts via mail or fax, recommendation to review the UPHP Provider Manual or other distributed materials, or by directing the practitioner to the appropriate website. Credentialing personnel may give the status on actions on a license, malpractice claims history, board-certification history, affiliation history, or if the application has missing documentation, and/or erroneous/conflicting information.

In the event a practitioner's or organization's license actions, malpractice claims history, school or residency completion, work history, board certification, accreditation or government survey or affiliation history obtained during the credentialing process varies substantially from the information provided on the application, or if there is cause to believe that any information was omitted, the practitioner or organization will be notified in writing and will be given 30 days to correct the erroneous information by responding in writing to the credentialing staff who requested it.

Credentialing Application

To be initially appointed into the panel of providers participating in, or be permitted to continue participating in UPHP's network, providers must satisfy the following listed acceptance/continued participation criteria:

- All applicants must enter into a Provider Participation Agreement with UPHP or serve under an existing group's Participation Agreement.

- All applicants must sign a release and attestation.

- All applicants must disclose on their application:
    - Full legal name.
    - Degree (MD, DO, NP, PA, MSW, etc.).
    - Gender.
    - Date of birth.
    - National Practitioner Identifier (NPI).
    - Previous names/aliases.
    - Languages spoken.
    - Specialty.
    - Applicable education.
    - Board certification status (for MD and DO).
    - Practice state license number (MI and/or WI).
    - DEA number.
    - Current hospital privileges, if any.
    - Practice address, location NPI and associated tax ID number.
    - Billing address, billing NPI and associated tax ID number.
    - Tax address and associated tax ID number.
    - Statement of primary care provider (PCP) or specialist status.
    - PCPs must provide their Covering Providers as well as their 24-hour medical coverage, admitting arrangements and hospitalized patient care, per CMS requirements.
    - Providers must provide copies of current professional liability insurance coverage with annual minimum limits of $200,000 per occurrence and $600,000 aggregate and must maintain current coverage.
        - Doulas require annual minimum limits of $500,000 per occurrence and $1,000,000 aggregate
    - Physicians Assistants, Nurse Practitioners, Nurse Midwives, and limited license behavioral health providers must have a UPHP network participating supervisor that is of the same scope of practice.
        - If practicing as a PCP, the supervisor must be readily available for consultation via telephone or video conference within 30 minutes.

Training and Board Certification Requirement
All physicians (MD or DO) must be board certified by an approved board in their primary practice specialty. A waiver from the board certification requirement may be given under certain circumstances.

All other providers (not MD or DO) must have completed the education and training required for their practice in the state.

Licenses and Certifications
Providers must hold valid, current medical licenses/required certifications issued by the state(s) in which they conduct their medical practice. Providers shall only practice within their scope, to the extent that their license (and training) will allow. Providers must provide information regarding any license that has been challenged, denied, revoked, suspended, restricted, reduced, limited, reprimanded, placed on probation, not renewed, or voluntarily or involuntarily relinquished with respect to licensure or certification.

DEA Certificate
Eligible providers must hold a valid and current Drug Enforcement Agency (DEA) registration in the state(s) of practice or provide a statement that they do not require such registration to deliver appropriate care to patients in UPHP's network. Providers must provide information regarding their DEA certificate that has been challenged, denied, revoked, suspended, restricted, reduced, limited, reprimanded, placed on probation, not renewed, or voluntarily or involuntarily relinquished with respect to certification.

Clinical Privileges
Providers must provide information regarding any prior loss, suspension, termination, voluntary relinquishment, restriction, or other adverse action with respect to clinical privileges at a licensed hospital. This information shall be in the form of a comprehensive narrative, to include all information relevant to the action taken and its resolution.

Work History
Providers must demonstrate a current, stable, and verifiable work history of a minimum of five consecutive years (including training) with no more than a five-month gap in employment during that five-year period. Providers shall provide complete documentation relative to any gaps of six months or more. This information shall be in the form of a comprehensive narrative, to include all information relevant to the gap in employment or work.

Providers shall also provide complete documentation relative to any involuntary termination or resignation of employment or other contractual arrangement pursuant to which they were engaged to furnish professional services. Providers shall not be admitted to UPHP's network to the extent any such involuntary termination or resignation, together with other factors, is determined by the Credentialing Committee to bear negatively upon their professional competence or conduct, or ability to successfully participate in the network.

Screening
Providers and the managing employee, owners, directors, subcontractors, and agents of the group with whom they work or are contracted or own, must be in good standing under the Medicare and Medicaid programs, adhering to all Medicare and Medicaid requirements.

UPHP screens all applicants, as well as in-network and out-of-network providers, against the U.S. Department of Health and Human Services Office of Inspector General (OIG) exclusion list and the System for Award

Management (SAM) list, prior to initial appointment and on a monthly basis. Providers must not be listed on the OIG or SAM lists if they wish to participate with the UPHP network.

UPHP screens the Medicare Opt-out list, the CMS Preclusion List and the Medicare Exclusions Database (MED) prior to initial appointment and on a monthly basis. Providers must not be listed on the Medicare Opt-out list, the CMS Preclusion List or the MED if they wish to participate with Medicare products in the UPHP network.

Providers shall provide a statement of management and criminal history information, as outlined in CMS's 42 CFR 455.101 through 455.106. The applicant must disclose the name and Social Security Number of their employer's managing employee. The applicant must also disclose any person with ownership or control interest in the provider or who is an agent or managing employee of the provider who has ever been convicted of a criminal offense related to a Medicare or Medicaid program or Title XX services program since the inception of those programs.

Disclosure Statements

- **Malpractice Suits**
  Providers shall provide complete documentation relative to any involvement in a malpractice suit, notice of intent, arbitration, or settlement arising out of their professional services, together with evidence of the circumstances of any such occurrence. This information shall be in the form of a comprehensive narrative, to include all information relevant to the claims and their resolution.
- **Professional Liability Denial or Cancellation**
  Providers shall provide complete documentation relative to any denial or cancellation of professional liability insurance.
- **Disciplinary Actions**
  Providers shall provide complete documentation relative to any professional disciplinary action to which they were subject. This information shall be in the form of a comprehensive narrative, to include all information relevant to the action taken and its resolution. The Credentialing Committee, in the exercise of its discretion, shall make the determination of sufficiency based on the information provided.
- **Professional Conduct**
  Providers shall provide complete documentation relative to any occurrences involving their failure to conduct themselves with a professional demeanor or of engaging in abusive, inappropriate, illegal, or immoral behavior in professional matters. The foregoing includes any formal or informal reprimands, letters in their employment file, or other materials memorializing such conduct.
- **Criminal History**
  Providers must have an absence of a history of indictment or criminal conviction; or, in the case of a practitioner with this history, evidence must be provided, in the form of a comprehensive narrative, to include all information relevant to the action taken and its satisfactory resolution, that this history is not indicative of probable future substandard professional performance. A conviction within the meaning of this criterion shall include a plea or verdict of guilty or a plea of no contest.
- **Health Status**
  Providers shall provide complete documentation relative to any physical, mental health, or substance abuse problems which may interfere with their ability to practice their profession or facilitate cooperative working relationships, or which may pose a threat to their patients. In conjunction with this requirement, providers must provide any reasonably requested evidence of health status.

Quality of Care and Utilization Management (UM)
Providers may occasionally be asked to provide complete documentation relative to their quality of care and appropriateness of their UM of medical resources.

Compliance
Providers must comply with all UPHP rules, regulations, policies, processes, and the terms of their Provider Participation Agreements, as well as with the rules and laws of the State of Michigan and Wisconsin (as applicable) and the federal government.

Providing Care to UPHP Members
Providers must demonstrate their willingness to provide appropriate and necessary emergency or non-emergency medical treatment within the scope of their expertise to any UPHP member seeking treatment.

Misrepresentation
Providers shall not be found to have made any misrepresentations to UPHP's Board of Directors, Credentialing Committee, employees, agents, or enrollees, including without limitation, any representations relative to the provision of services to enrollees.

Providers shall provide accurate and complete information on their applications, timely response to requests for additional information and must promptly notify UPHP Credentialing regarding any changes in their status, including without limitation, any changes to the responses furnished in connection with their applications. Any providers who do not comply with the foregoing shall have their applications considered incomplete and shall not be processed.

Inability to Perform Essential Functions
Providers shall provide documentation relative to any fact or circumstance, whether relating to the acceptance/ continued participation criteria, which potentially may affect his or her ability to deliver appropriate care to patients in UPHP's network.

CHAMPS Enrollment
UPHP cannot process claims payment for UPHP Medicaid, Healthy Michigan Plan, or Children's Special Health Care Services claims until CHAMPS enrollment takes place. Providers can enroll in CHAMPS at https://milogintp.michigan.gov. CHAMPS Provider Support can be reached at (800) 292-2550.

If a provider fails to meet any of the above requirements upon initial credentialing, they may be denied participation with UPHP's network by the health plan staff, Medical Director, and/or Credentialing Committee. If a participating provider falls out of compliance with any of the above requirements, they may be terminated from the network. More information regarding denials, terminations and hearings can be found below.

Updates or Changes

Providers must notify UPHP of any changes to status, including, but not limited to, any changes to their license, DEA Certificate, professional liability insurance coverage, board certification, Medicare and Medicaid participation, legal name, open/closed status, street address, phone number, and office hours or other changes that affect availability to ensure accuracy of UPHP's Provider Directory, or to pay claims or perform credentialing processes. Updates and/or changes should be submitted to the UPHP Provider Relations Department.

Change in Employment

Providers participating in UPHP's network under a group contract are no longer considered contracted with UPHP immediately upon the termination of their contractual affiliation with that group. These providers are subject to immediate and automatic termination from UPHP's network, without the opportunity to exercise any due process rights. Providers may contact UPHP to determine eligibility to contract with UPHP on an individual basis or under another group.

Disciplinary Actions by UPHP

Non-compliance with policy, procedure, contract, or addenda may be investigated and reviewed by UPHP Provider Relations or Compliance staff. Disciplinary and adverse action(s) may be progressively severe depending upon the nature and seriousness of the infraction(s). Actions and recommendations from the UPHP Medical Director for adverse action(s) regarding major/severe issues, which involve restriction, suspension, or termination, will be forwarded to the Credentialing Committee for review. Adverse action taken by the Credentialing Committee, against a provider, shall be approved by the UPHP Management Committee.

Network providers of UPHP are expected to promote quality of care and ensure compliance with regulatory standards and UPHP's contracts, addenda, policy, procedures, competency standards and conduct standards. In the event that UPHP takes adverse action against a provider, the network provider has an opportunity to appeal this recommendation. The provider must notify UPHP, in writing, of the intent to appeal the adverse action within 30 days of written notification from UPHP to provider of UPHP's recommendation to take such adverse action.

Provider Hearings and Appeals

If an adverse action is taken against a network provider—based upon the provider's professional competence, conduct, or if the provider's participation agreement is terminated by UPHP with or without cause—the provider has the right to an appeal hearing. In UPHP's sole discretion, UPHP may also offer an appeal to those providers who UPHP takes adverse action against for reasons that are not related to the provider's professional conduct or competence.

Notice of Action

When UPHP recommends taking adverse action against a provider for reasons based upon the provider's professional conduct or competence, the provider has the right to appeal UPHP's recommendation before such adverse action becomes final.

Notification by UPHP to Provider of Recommendation to Take Adverse Action: UPHP shall provide provider with certified written notification of UPHP's intent to take adverse action against provider. Such notification shall clearly state the reasons for UPHP's recommendation.

The notice of adverse action must contain:

1. A concise statement of the provider's alleged acts or omissions that caused UPHP to recommend adverse action.

2. A list by number of any specific or representative patient/member records in question.

3. Any other reasons or issues that formed the basis of the recommendation to take adverse action.

The notification shall explain that the recommendation shall not become final until provider has either (1) exercised his or her appeal rights, or (2) effectively waived his or her appeal rights. The letter shall also advise provider that provider has the right to appeal UPHP's recommendation within 30 days from the date of the notification described here. The provider shall also be advised of his or her right to be represented by counsel or any other person of the provider's choice at the hearing.

Request for a Hearing

A provider has 30 days after receiving written notification from UPHP of its recommendation to take adverse action against the provider to file a written request to appeal the decision via a fair hearing. The request must be delivered to the UPHP Medical Director either in person or by certified or registered mail. If the provider wishes to be represented by an attorney at the hearing, the request for the hearing must state this wish. Likewise, UPHP will notify the provider if counsel will represent them.

A disciplined provider who fails to request a hearing in writing within 30 days effectively waives the right to any hearing or appellate review to which the provider might otherwise have been entitled. A waiver constitutes acceptance of the recommendation, and such recommendation shall become final and effective on the date the provider has waived the appeal. UPHP shall communicate this in writing to the provider and as required by law, notify state agencies and data banks.

Medical Record Standards

UPHP requires medical records to be maintained in a manner that is current, detailed, and organized to facilitate communication/coordination of care and support the services that were provided. UPHP has established medical record standards to ensure that network practitioners and providers follow the National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS), and Michigan Department of Health and Human Services (MDHHS) requirements.

UPHP has established medical record standards that requires network practitioners and providers to maintain medical record standards which:

- Facilitate record maintenance in a detailed, comprehensive manner that conforms to good professional medical practice
- Require that medical records be signed and dated
- Permit effective professional medical review and medical audit processes
- Facilitate a system for follow-up treatment
- Include written policies and procedures for the maintenance of medical records which address timeliness, accuracy of documentation and confidentiality
- Provide that records be readily accessible to permit prompt and systematic retrieval of information
- Require medical record retention following CMS and MDHHS guidelines

Medical records must include at a minimum:

- History and Physicals
- Documentation of clinical findings and evaluation for each visit
- Problem/Condition list
- Allergies and adverse reactions
- Medications
- Preventive services/risk screening
- Outpatient and emergency care reports
- Inpatient discharge summaries
- Specialist referrals
- Ancillary care
- Diagnostic test findings (lab, radiology, etc.)
- Immunization records
- Prescriptions for medications

As applicable, the following are maintained in the medical record:

- Consultation reports
- Release of information forms signed by member or parent/guardian
- Advanced care directives

For primary care records the following must be present:

- All services provided directly by a practitioner who provides primary care services.
- All ancillary service and diagnostic tests ordered by the practitioner.
- Reports of all diagnostic and therapeutic services for which a member was referred by a practitioner, such as
    - Home health nursing
    - Specialty physician
    - Hospital discharge
    - Physical therapy

When a member changes his or her PCP, the former PCP must forward all the member's medical records or copies of medical records to the new PCP within ten (10) working days from receipt of a written request.

UPHP network practitioners and providers are required to permit MDHHS and CMS personnel, or authorized agents, access to all information concerning any services that may be covered by Medicare or Medicaid. This access does not require an authorization from the member because the purpose for the disclosure is permitted under the HIPAA Privacy rule. UPHP must be permitted access to all information relating to services reimbursed by the health plan.

Network practitioners and providers are required to have their medical records be stored securely with only authorized personnel having to records and that staff receive periodic training in member information confidentiality.

Providers and practitioners must retain member records for a minimum of 7 years following termination, or a longer period if required by state or federal law.

Primary Care Provider Responsibilities

Access to Care Standards

Upper Peninsula Health Plan (UPHP) defines a primary care provider (PCP) as a medical practitioner responsible for supervising, coordinating, and providing all primary care services to members. The PCP is also responsible for initiating referrals for specialty care, continuity of a member's health care, and maintaining the member's medical records, which includes documentation of all services provided by the PCP as well as any specialty services.

Providers who may serve as PCPs are family/general practice physicians, OB/GYN physicians, internal medicine physicians, and pediatricians, nurse practitioners, physician assistants, and other physician specialists when appropriate for a member's health condition.

A PCP must be accessible 24 hours a day, seven days a week, either personally or through coverage arrangements with a designated contracted PCP.

After-hours coverage must meet the following requirements:

- Provides instructions for an emergency situation.
- Provides instructions on how to obtain after-hours care.

As applicable, PCPs contracted with UPHP must meet or exceed the following standards for access by patients:

1. Office hours: PCPs must be available at least 20 hours per week. Routine physician and office visits must be available during regular and scheduled office hours.
2. Emergent appointments: Emergencies must be handled immediately, or the member should be referred to the nearest hospital emergency room.
3. Urgent appointments: All urgent and symptomatic office visits must be available to members within 48 hours. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring immediate attention.
4. Routine appointments: Preventive and primary care for non-urgent conditions (such as well-care exams, tests, and immunizations) should be scheduled within four weeks for children ages zero to 17 years and within five weeks for adults 18 and older.
5. After-hours care: When a PCP office is closed, the PCP must provide member access and availability to physician services, 24 hours a day, seven days a week for urgent care for symptomatic conditions.

Provider Change Notification Requirements

Providers must notify UPHP in writing at least 60 days prior to changes in physician staffing, practice location changes, and billing address and tax ID changes. To submit changes, locate the "Information Update Form" found on UPHP's website at https://www.uphp.com/providers/forms-links/ or notify UPHP Provider Relations via email at uphpproviderrelations@uphp.com.

Completed forms should be mailed, faxed or emailed to:

Upper Peninsula Health Plan
Attn: Provider Relations
853 West Washington Street
Marquette, MI 49855
Fax: 906-225-1087

For further information about updating provider information, please contact UPHP Provider Relations at 800-835-2556 or uphpproviderrelations@uphp.com.

Children in Foster Care Requirements

All children in foster care younger than 21 years of age must receive a full medical examination and screening for potential mental health issues by a PCP within the first 30 days of entering foster care. All children in foster care are eligible for Medicaid from the first day of the month of entry into foster care. PCPs must verify the child in foster care's eligibility and enrollment status and complete the health maintenance visit regardless of whether the child in foster care recently received a health maintenance visit prior to entering the foster care system. These well child visits are covered by UPHP when the youth is placed in foster care and while in foster care. For further guidance regarding the requirements for children in foster care, please visit the Children in Foster Care section of the MDHHS Medicaid provider manual at MedicaidProviderManual.pdf (state.mi.us).

Compliance

UPHP is committed to comply with all applicable laws and regulations. UPHP has policies and procedures in place to ensure compliance and regulatory standards are met. Policies and procedures are updated as needed to incorporate changes in regulation and reviewed at least annually. UPHP must comply with all provisions of the federal and Michigan Medicaid False Claims Act. This includes establishing and maintaining written policies for employees, contractors, and agents of UPHP regarding detection and prevention of fraud, waste, and abuse (FWA) and whistleblower protections. These policies and other resources are available on the UPHP website at https://www.uphp.com/providers/provider-resources/fraud-waste-and-abuse-2/. Additional information is included later in this chapter.

Definitions

Practices that are inconsistent with sound fiscal, business, or medical practices, that result in an unnecessary cost to the Medicare and/or Medicaid Programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care are considered FWA.

Specifically:

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under the applicable federal or state law. 42 CFR 455.2.

Waste: Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare and/or Medicaid Programs. Waste is generally not considered to be caused by criminally negligent actions but rather a misuse of resources.

Abuse: Actions that may, directly or indirectly, result in unnecessary costs to the Medicare and/or Medicaid Programs, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Examples of FWA:

	Fraud	Waste	Abuse
Provider	Kickbacks, altering medical records to receive a higher payment	Billing for unnecessary items or services, prescribing more medications than necessary to treat a specific condition	Unknowingly charging in excess for services and supplies, unknowingly unbundling and/or upcoding
Member	Identity theft, sharing UPHP identification cards with nonmembers, forging prescriptions	Misrepresentation of personal information to receive benefits	Doctor shopping

Preventing FWA

UPHP and other state and federal agencies are collaborating to help prevent FWA. Here are ways you can help prevent health care FWA:

- Verify eligibility at each member visit.
- Keep a copy of a photo ID in the member's medical records.
- Bill according to standard billing guidelines.

Reporting FWA

Any employee, member/family member, provider, first tier, downstream, or related entity (FDR) of UPHP who suspects an improper or illegal activity associated with UPHP is required to report such suspicion to the UPHP Compliance Officer. You can report anonymously. Any employee, member/family member, FDR, who reports such matters shall not be subject to retaliation or harassment in any manner. An employee of UPHP engaging in such conduct will be subject to discipline, up to and including termination.

Suspected cases of FWA should be reported to UPHP's Compliance Officer. You have the right to report your concerns anonymously to UPHP, the Michigan Department of Health and Human Services Program Investigation Section, or the US Department of Health and Human Services Office of Inspector General. When reporting an issue, please provide as much information as possible as this will increase the likelihood of a successful review and resolution. Remember to include the following information when reporting suspected fraud or abuse:

- The nature of the complaint.
- The names of individuals and/or entity involved in suspected FWA including address, phone number, member ID number, and any other identifying information.

You may report possible FWA to:

UPHP Compliance Officer
853 West Washington Street
Marquette, MI 49855
Phone: 906-225-5081
(Anonymous if preferred)

Michigan Department of Health and Human Services Office of Inspector General
P.O. Box 30062
Lansing, MI 48909
Toll Free: 1-855-MI-Fraud (1-855-643-7283)
Online: https://www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/Report-Medicaid-Fraud-and-Abuse
You may remain anonymous.

U.S. Department of Health and Human Services Office of Inspector General
Attn: OIG Hotline Operations
P.O. Box 234989
Washington, DC 20026
Toll-Free: 1-800-HHS-TIPS (1-800-447-8477)
Online: https://tips.oig.hhs.gov/
You may remain anonymous

Deficit Reduction Act

On Feb.8, 2006, President George W. Bush signed the Deficit Reduction Act of 2005 into law. The Deficit Reduction Act contains many provisions reforming Medicare and Medicaid that are designed to reduce program spending.

UPHP is a participant in the State of Michigan Comprehensive Health Care Program and receives reimbursement from Medicaid for health care services provided to Medicaid beneficiaries, including dispensing of prescription medications. As an entity that receives payments from Medicaid, which meet the requirements under Section 6032 of the Deficit Reduction Act of 2005, UPHP is required to comply with certain provisions of the Deficit Reduction Act.

Under the Deficit Reduction Act, UPHP is required by law to establish certain policies and provide all employees with information regarding: (1) the federal False Claims Act and similar state laws, (2) an employee's right to be protected as a whistleblower, and (3) UPHP's policies and procedures for detecting and preventing FWA in state and federal health care programs. Further, contractors, subcontractors, agents, and other persons that or who, on behalf of UPHP, furnish or otherwise authorize the furnishing of Medicaid health care items or services, perform billing or coding functions, or are involved in the monitoring of health care provided by UPHP, are required to adopt these policies and procedures to continue to do business with UPHP.

This document sets forth UPHP policies and contains information required by law under the Deficit Reduction Act. Affected entities who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. UPHP will take steps to monitor UPHP contracted providers to ensure compliance with the law.

False Claims Acts

One of the primary purposes of false claims laws is to combat FWA in government health care programs. False claims laws do this by making it possible for a government to bring civil action to recover damages and penalties when health care providers submit false claims. UPHP must comply with these laws; contracted providers and their staff have the same obligation to report any actual or suspected cases of FWA. Both the Federal False Claims Act and the Michigan Medicaid False Claims Act laws often permit Qui Tam suits, often referred to as "whistleblower" provisions, which are lawsuits filed by laypeople, typically employees or former employees of health care providers that submit false claims, on the government's behalf. The government may decide to take over the case, but if it declines to do so, the whistleblower may still pursue the suit. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government, as well as attorney fees and costs.

The Federal False Claims Act and Michigan Medicaid False Claims Act contain some overlapping language related to personal liability. For example, the Medicaid False Claims Act has the following triggers:

- Presents or causes to be presented to the state, a Medicaid claim for payment where the person receiving the benefit or payment is not authorized or eligible to receive it.
- Knowingly applies for and receives a Medicaid benefit or payment on behalf of another person, except pursuant to a lawful assignment of benefits, and converts that benefit or payment to their own personal use.
- Knowingly makes a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program.
- Knowingly makes a claim under the Medicaid program for a service or product that was not provided.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against due to their role in furthering a false claim are entitled to:

- Employment reinstatement at the same level of seniority.
- Two times the amount of back pay plus interest.
- Compensation for special damages incurred.

Provider Self Audit and Disclosure of Overpayments

UPHP encourages providers to conduct regular self-audits to ensure receipt of accurate payment(s) from UPHP. Bills and medical records should also be reviewed for compliance with applicable coding, billing, and documentation requirements. Resources are available to help providers structure a self-audit, including resources from the Centers for Medicare and Medicaid Services, located here:

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education

Medicare and Medicaid program funds must be returned when identified as improperly paid or overpaid. If a provider identifies improper payment or overpayment of claims from UPHP, the improperly paid or overpaid funds must be returned to UPHP within 60 days from the date of discovery of the overpayment. Providers may return improper or overpaid funds to UPHP by submitting a copy of the UPHP Explanation of Payment and the refund check by mail to UPHP Claims:

Upper Peninsula Health Plan
Attn: Claims
853 West Washington Street
Marquette, MI 49855

The Health Insurance Portability and Accountability Act (HIPAA) Requirements and Information

UPHP's Commitment to Patient Privacy

UPHP strives to protect and maintain the confidentiality, integrity, and availability of electronically transmitted and maintained member information, medical records, research information, and business operations; and shall strive to comply with applicable federal and state laws regarding the privacy and security of members protected health information (PHI).

Provider/Practitioner Responsibilities

UPHP expects that all contracted providers/practitioners will respect the privacy of UPHP members and comply with all applicable laws and regulations concerning the privacy of patient and member PHI.

Applicable Laws

Provider/practitioners must comprehend all state and federal health care privacy laws applicable to their practice and organization. There are various laws that providers/practitioners must comply with; most of Michigan's health care providers/practitioners are subject to laws and regulations pertaining to privacy of health information including, but not limited to:

- Federal Laws and Regulations
    - HIPAA
    - Medicare and Medicaid laws
- Michigan Medical Privacy Laws and Regulations

While HIPAA provides a base for patient privacy, state laws should be followed in certain situations, particularly if the state law is more strictly regulated than HIPAA. Providers/practitioners should consult with their own legal counsel to address their specific situation.

Patient Rights

Patients have various rights under HIPAA regarding medical information. UPHP providers/practitioners must allow patients to exercise any of the following rights that apply to the provider/practitioner's practice:

1. **Notice of Privacy Practices:** Providers/practitioners that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explain the patient's privacy rights and the process the patient should follow to exercise those rights. The provider/practitioner should obtain a written acknowledgement that the patient received the notice of privacy practices.

2. **Right to Request Restriction on Uses and Disclosures of PHI:** Patients may request that a health care provider/practitioner restrict its uses and disclosures of PHI. The provider/practitioner is not required to agree to any such request for restrictions.

3. **Right to Request Confidential Communications:** Patients may request that a health care provider/practitioner communicate PHI by alternative means or at alternative locations. Providers/practitioners must accommodate reasonable requests by the patient.

4. **Right to Request Patient Access to PHI:** Patients have the right to access their own PHI within a provider/practitioner's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a provider/practitioner contains the patient's medical record, as well as billing and other records used to make decisions about the member's care or payment for care.

5. **Right to Request Amendment of PHI:** Patients have the right to request that the provider/practitioner amend information in their designated record set.

6. **Right to Request Accounting of PHI Disclosures:** Patients may request an accounting of disclosures of PHI unrelated to health care, treatment, payment, or operations, made by the provider/practitioner within the past six-year period.

HIPAA Security

UPHP has adopted this General HIPAA Security Regulations Policy to comply with HIPAA and the Department of Health and Human Services (DHHS) security and privacy regulations, as well as our duty to protect the confidentiality and integrity of confidential medical information as required by law, professional ethics, and accreditation requirements.

UPHP shall strive to protect and maintain the confidentiality, integrity, and availability of electronically transmitted and maintained member information, medical records, research information and business operations; and shall strive to comply with applicable laws and regulations.

In doing so, UPHP will take steps to:

1. Ensure the confidentiality, integrity and availability of all electronic PHI that it creates, receives, maintains or transmits;

2. Protect against any reasonably anticipated threats or hazards to the security or integrity of electronic PHI;

3. Protect against any reasonably anticipated uses or disclosures of electronic PHI that are not permitted or required under UPHP policies related to privacy of PHI; and

4. Ensure that workforce members comply with UPHP security policies.

The HIPAA security policies are in addition to all other UPHP Information Systems policies and privacy policies for all electronically held information and for information systems and devices that transmit or store electronic PHI.

HIPAA Transactions and Code Sets
UPHP strongly supports the use of electronic transactions and providers are encouraged to submit claims and other transactions to UPHP using electronic formats. UPHP is committed to complying with all HIPAA Transaction and Code Sets standard requirements.

External Resources

UPHP administers the plan in accordance with the contractual obligations, requirements, and guidelines established by CMS and MDHHS. Below are several helpful links on both CMS and MDHHS's websites that may be referred to for additional information.

Medicare Managed Care Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs-Items/CMS019326

Medicare Prescription Drug Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/Pub100_18.pdf

Medicare Claims Processing Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912

Medicaid Provider Manual: https://www.michigan.gov/mdhhs/doing-business/providers/providers/medicaid/policyforms/medicaid-provider-manual

Michigan Department of Health and Human Services: https://www.michigan.gov/mdhhs

Healthy Michigan Plan: https://www.michigan.gov/mdhhs/assistance-programs/healthcare/healthymichigan

Children's Special Health Care Services: https://www.michigan.gov/mdhhs/assistance-programs/cshcs/cshcs-provider-information-page

MIChild: https://www.michigan.gov/mdhhs/assistance-programs/healthcare/childrenteens/michild

Healthy Kids Dental: https://www.michigan.gov/mdhhs/assistance-programs/healthcare/childrenteens/hkdental

UPHP

UPPER PENINSULA HEALTH PLAN

Last Updated: December 2023

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